Supreme Court, U.S.
FILED
JUN 15 1993
OFFICE OF THE CLERK

92-2020

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1992

JONATHAN MARSH, a minor,
by and through his Guardian
Ad Litem, Sharon Marsh,

Plaintiff-Petitioner,

v.

ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,

Defendant-Respondent.

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

WILLIAM M. SHERNOFF
Counsel of Record
SHARON J. ARKIN
SHERNOFF, BIDART & DARRAS
600 South Indian Hill Boulevard
Claremont, California 91711
Telephone: (909) 621-4935

Counsel for
Plaintiff-Petitioner
Jonathan Marsh

Lorraine Mitchell Legal Briefs

732 E. WASHINGTON BOULEVARD
LOS ANGELES, CALIFORNIA 90021-3088
(213) 747-5631 • FAX: (213) 747-5843

CONTENTS REPRODUCED FROM FURNISHED PRETYPED COPY.

QUESTIONS FOR REVIEW

1. What rules of contract interpretation should be applied to construction of insurance policies issued to employee welfare benefit plans for medical insurance benefits under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. section 1001, et seq.?

2. Does the doctrine of vesting of benefits apply where the insurance policy language supports application of that doctrine in the interpretation of medical insurance policies subject to ERISA?

3. Where an insurer providing medical insurance coverage to an employee

benefit plan fails to inform the beneficiaries of the plan that the conversion policy offered under the policy has significantly reduced benefits, is the insurer obligated to issue a conversion policy with benefits equivalent to the terminated group insurance coverage?

PARTIES TO THE PROCEEDING

Plaintiff and Petitioner:

JONATHAN MARSH, by and through his Guardian ad Litem, Sharon Marsh

Defendant and Respondent:

ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

QUESTIONS FOR REVIEW . . 1

PARTIES TO THE PROCEEDING . . 3

STATEMENT OF GROUNDS FOR JURISDICTION 1

STATEMENT OF THE CASE 3

ARGUMENT 16

A. COMMON LAW RULES OF ADHESION CONTRACT INTERPRETATION SHOULD BE ADOPTED AS THE FEDERAL RULE FOR INTERPRETATION AND CONSTRUCTION OF INSURANCE POLICIES ISSUED TO EMPLOYEE WELFARE BENEFIT PLANS . . . 16

B. WHERE THE CONTRACT TERMS SUPPORT THE APPLICATION OF VESTING OF BENEFITS, ERISA PROPERLY PERMITS SUCH VESTING IN THE CONTEXT OF MEDICAL

INSURANCE BENEFITS UNDER AN EMPLOYEE WELFARE BENEFIT PLAN 24

C. HAVING FAILED TO NOTIFY THE BENEFICIARIES OF THE PLAN THAT CONVERSION BENEFITS WERE SIGNIFICANTLY REDUCED FROM THE GROUP POLICY, ALLSTATE IS REQUIRED TO PROVIDE EQUIVALENT BENEFITS UNDER THE CONVERSION POLICY 36

CONCLUSION 45

APPENDIX

TAB	DOCUMENT
A	MEMORANDUM ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT
B	ORDER DENYING PETITION FOR REHEARING BY THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT
C	29 U.S.C. SECTION 1001, ET SEQ.
D	ORDER GRANTING PRELIMINARY INJUNCTION OF THE UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
E	ORDER ON SUMMARY JUDGMENT OF THE UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA

TABLE OF AUTHORITIES

PAGE

CASES

Armistead v. Vernitron, 944 F.2d 1287, 1297 (6th Cir. 1991) 32, 33

Blue Cross-Blue Shield of Alabama v. Turner, 195 So.2d 807 (1967) 25

Branscum v. Service Life Ins. Co., 234 Ark. 463, 352 S.W.2d 586 (1962) . 25

Brown v. Blue Cross & Blue Shield of Mississippi, 427 S. 139 (1983) . . 25

Danzig v. Dikman, 78 A.2d 303, 434 N.Y.S.2d 217 (1980), aff'd., 53 N.Y.2d 926, 423 N.E.2d 402, 440 N.Y.S.2d 925 (1981) 25

Erwin v. Limited Benefit Life Ins. Co., 70 N.M. 138, 371 P.2d 791, (1962) . . 25

Evans v. Safeco Life Ins. Co., 916 F.2d 1437 (9th Cir. 1990) 17, 18, 23

Fassio v. Montana Physicians' Service, 170 Mont. 320, 553 P.2d 998 (1976) . 25

Fields v. Blue Shield of Calif., 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), reh'g denied October 21, 1985 . . . . . .26, 28

FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403 (1990) 3

In re White Farm Equipment Co., 788 F.2d 1186, (6th Cir. 1986) 32

International Resources, Inc. v. New York Life, 950 F.2d 294 (6th Cir.1991) 31, 33

Kunin v. Benefit Trust Life Ins. Co., 898 F.2d 1421 (9th Cir. 1990), amended, 910 F.2d 534 . . . . 17, 18, 23

Lutsky v. Blue Cross Hospital Service, Inc., 695 S.W.2d 870 (1985) 25

Myers v. Kitsap Physicians Services, 78 Wash.2d 286, 474 P.2d 109 (1970) 25, 26

Sparks v. Republic National Life Ins. Co., 132 Arizona 529, 647 P.2d 1127 (1982) 24

Sur v. Glidden-Durkee, a division of S.C.M. Corp. 681 F.2d 490 (7th Cir. 1982) 39

Wardlow v. Kalispell General Hospital, 164 Mont. 59, 518 P.2d 1164 (1974) . 25

Washer v. Continental Casualty Co., 418 S.W.2d 900 (1967) 26

STATUTES

28 U.S.C. section 1254 1

29 U.S.C. section 1001, et seq. . . . 1

29 U.S.C. section 1001-1461 (1982)

section 2(b) 20

29 U.S.C. section 1144 19

29 U.S.C. §1053 32

TREATISES

H.R. Rep. No. 807, 93r Cong., 2d. Sess, reprinted in 1974 U.S. Code Cong. & Admin.
News 4670, 4678-9, 4680 ("House Report No. 807") 19

S. Rep. No. 383, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin.
News 48990 ("Senate Report No. 383") 19

No. _____

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1992

JONATHAN MARSH, a minor,
by and through his Guardian
Ad Litem, Sharon Marsh,

Plaintiff-Petitioner,

v.

ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,

Defendant-Respondent.

PETITION FOR WRIT OF CERTIORARI

STATEMENT OF GROUNDS FOR JURISDICTION

The Memorandum order of the United States Court of Appeals for the Ninth Circuit which is sought to be reviewed was issued on January 22, 1992. (See Appendix, Tab A.)

A petition for rehearing was timely filed by plaintiff/appellant on February 7, 1992.

The United States Court of Appeals for the Ninth Circuit issued its denial of the petition for rehearing on March 17, 1993. (See Appendix, Tab B.)

This honorable Court has jurisdiction to review the judgment by writ of certiorari under 28 U.S.C. section 1254.

This action arises under 29 U.S.C. section 1001, et seq., the Employee

Retirement Income Security Act ("ERISA"). The ERISA statutes are included within the Appendix at Tab C.

STATEMENT OF THE CASE

ERISA, and its application, affects millions of Americans who receive their health and medical insurance benefits through employment. This action presents critically important questions of how insurance policies issued by insurance companies to employee benefit plans are to be interpreted and construed.[1]

---

[1] This honorable Court's opinion in FMC Corp. v. Holliday, 498 U.S. 52, 111 S.Ct. 403 (1990), made clear that the rules to be applied to ERISA plans which are self-funded may not necessarily be the same as those applied to plans underwritten by the actual purchase of insurance. This case presents the argument that the special rules of contract construction in regard to insurance policies should be applied, at the very least, to underwritten plans. It is an issue for another case as to whether those same special construction rules should be applied to self-funded plans.

JONATHAN MARSH, now 14 years old, suffered anoxic brain damage as the result of a swimming pool accident in October, 1982 when he was four years old. Since that accident, MARSH has remained in a persistent vegetative state and is plagued by frequent seizures, electrolyte instability and cardiopulmonary compromise. As the result of his condition, MARSH is completely dependent on home health care nurses to provide him with care, treatment and medical assistance.

On the day of his drowning accident, MARSH was insured under a group insurance policy issued to his father's employer, Universal Broadcasting, for major medical and health insurance. The policy was underwritten by The Equitable Life

Assurance Society of the United States. In January, 1984, the Equitable policy was terminated and the underwriting of the plan was assumed by The Travelers Insurance Company. The Travelers policy was, in turn, terminated and the group policy was then underwritten by ALLSTATE.

ALLSTATE, like its predecessors, provided coverage for major medical health costs and expenses. While insured under the ALLSTATE policy, MARSH's father left his employment with Universal Broadcasting, but elected to maintain the ALLSTATE coverage under his COBRA rights. On or about May 1, 1989, however, ALLSTATE unilaterally terminated the group coverage. ALLSTATE offered to extend the benefits available under the group insurance policy for one

calendar year from the date of termination of that policy. Upon the threatened termination of that extension of benefits, MARSH filed a complaint in the United States District Court seeking declaratory relief, damages for breach of fiduciary duty and injunctive relief. An Application for Temporary Restraining Order was filed in the action and a Temporary Restraining Order was issued by the District Court. After briefing and hearing on the motion for preliminary injunction, the District Court determined that the ALLSTATE policy was ambiguous in regard to continued coverage for a loss which arose prior to termination of the policy and issued its preliminary injunction prohibiting ALLSTATE from terminating MARSH's nursing care benefits. (See

Appendix, Tab D.)

At argument on the preliminary injunction, Judge Bonner recommended that the action be resolved by way of cross-summary judgment motions. Inexplicably, in ruling on the cross-summary judgment motions, Judge Bonner completely reversed his prior findings on the preliminary injunction and ruled that the ALLSTATE policy was not ambiguous and did not provide continuing coverage. (Appendix, Tab E.) The District Court then denied MARSH's summary judgment motion, granted ALLSTATE's motion and dissolved the preliminary injunction. (Appendix, Tab E.)

This appeal involves the doctrine of "vesting". Care must be taken, however, to refrain from importing more

into that phrase than is justified under the circumstances. It is not a magical incantation used in an attempt to impose unjustified duties on an insurer.

"Vesting", as applied to this case, is nothing more than a shorthand phrase for a circumstance where an insurance policy, either by its express terms or *as the result of an ambiguity in its terms*, provides continuing coverage after the termination of the policy for a loss which arose before the termination of the insurance policy. Under the doctrine of vesting, where an injury or illness arises before the termination of the medical insurance policy, the policy provides for continuing treatment for only *that* injury or illness even after the termination of the policy for purposes

of any other injury or illness.

The ALLSTATE policy specifically states that "[t]he end of insurance will not affect any claim made for a *loss* that took place while the insurance was in force." (Emphasis added.) As ALLSTATE itself admitted in its Opposition to the Preliminary Injunction, this is a classic "vesting" provision. Thus, the policy expressly provides that the termination of the insurance policy does not affect the insured's right to continuing insurance for a *loss* that arose prior to the termination.

ALLSTATE argued below, and the District Court and the appellate court ruled, however, that despite this express statement of continuing benefits, the portions of the policy

which deal with the payment of "Eligible Expenses" for medical treatment require that the expenses for treatment, to be covered, must be incurred "while insured". Both the District Court and the Ninth Circuit Court of Appeals concluded that if the expense was incurred after the termination of the policy, there was no coverage. But this ignores the language of the termination provision which provides that so long as a "loss" occurred prior to termination, "*coverage*" for that "loss" still exists and expenses for treatment incurred for that "loss" are incurred while "coverage" for that "loss" is still in effect.

The Ninth Circuit reasoned that because the "Eligible Expenses" provision could be read in harmony with

the termination provision to support the conclusion that all benefits and coverage terminated upon the termination of the policy itself, there was no ambiguity and MARSH was not entitled to further benefits.

However, the appellate court's analysis does not take into account the "*contra proferentem*" rule of contract construction which is uniformly applied by common law courts, particularly in the context of insurance policy construction. In this case, the two contract provisions can reasonably be construed either to provide coverage or to exclude coverage. The strongest evidence of this is the fact that the District Court did just that. Upon motion for preliminary injunction, the District Court determined that vesting

applied under a reasonable construction of the policy provisions and upon motion for summary judgment determined that a reasonable construction of the policy provisions resulted in termination of benefits.

The appellate court overlooked the obvious. The insuring provision portion of the policy provides that insurance continues as to the "vested" condition despite the termination of the policy. The "Eligible Expense" provision of the medical insurance portion of the policy only requires that the expense be incurred "while insured". As long as the expense is incurred for treatment of the vested condition, the insurance is still continuing for that condition and the insured incurs the expense while insured.

ALLSTATE wrote the policy. Had it intended to require that the medical expense be incurred during the term of the policy rather than during the term of the insurance coverage, it could have stated that. ALLSTATE need only have stated that an expense, to be covered, must be incurred prior to termination of the policy. This is the logical way to state the condition. But ALLSTATE did not do that. Rather, ALLSTATE keyed the coverage to the existence of "insurance" rather than to the effective date of the policy.

Even were ALLSTATE's argument that the "Eligible Expense" definition required the expense to be incurred during the policy term (as opposed to being incurred "while insured"), the promise that the termination of the

policy would not affect any claim for a loss which took place while the insurance was in force creates a core conflict and ambiguity.

The District Court and the appellate court, in construing the policy failed to apply rules of construction which favored the insured beneficiary. Given the important public policy considerations in regard to insurance and ERISA in general, it is critically important to establish federal common law rules for interpretation and construction of insurance policies issued to employee welfare benefit plans so that ERISA's express purpose in safeguarding employee benefits can be fulfilled and implemented.

In turn, application of contract

construction rules developed in general insurance law require the application of the vesting doctrine in this case. Similarly, those rules and proper application of public policy requires that the conversion policy promised in the group policy provide benefits equivalent to those of the group policy absent a clear and express limitation or notification in the group policy that any conversion benefits will be limited.

These are issues of vital importance to the millions of Americans who obtain their medical insurance through their employment. These are also issues as to which there are numerous and conflicting resolutions throughout the Circuit Courts of Appeal. As such, this Court should grant certiorari in this case in order to

delineate the rules of construction and interpretation of insurance policies issued to ERISA plans.

ARGUMENT

A.

COMMON LAW RULES OF ADHESION CONTRACT INTERPRETATION SHOULD BE ADOPTED AS THE FEDERAL RULE FOR INTERPRETATION AND CONSTRUCTION OF INSURANCE POLICIES ISSUED TO EMPLOYEE WELFARE BENEFIT PLANS

There is currently much heated debate in the legal literature about whether the common law rule of construing any ambiguities against the

drafter of an adhesion contract should be applied in the context of ERISA plans. In its amended opinion, the Ninth Circuit Court of Appeals in Kunin v. Benefit Trust Life Ins. Co., 898 F.2d 1421 (9th Cir. 1990), amended, 910 F.2d 534, held that the rule that ambiguities should be construed against the insurer (the rule of *contra proferentum*) should apply to insurance policies issued to ERISA plans. Although some commentators have attempted to construe the Kunin rationale as being much broader than it is, it was made clear in Evans v. Safeco Life Ins. Co., 916 F.2d 1437 (9th Cir. 1990), that the state common law rule of construction is not adopted into ERISA law on the rationale that the rule of construction is saved from preemption. Rather, under Evans, insurance policies

issued to ERISA plans are to be interpreted under the uniform body of federal law. The issue which remains unresolved by the Ninth Circuit Court after Evans is whether the rule of *contra proferentum* is, or should be, part of the uniform federal common law which is to be applied to the interpretation of insurance policies issued to ERISA plans.

It is clear from the discussion in Kunin and from Justice Schroeder's dissent in Evans that this rule should reasonably form a part of the federal common law used to interpret insurance policies which are purchased by ERISA plans. To do otherwise would be to undermine the very purpose of ERISA.

Congress enacted ERISA to address particular social problems. Of specific

concern was the widespread abuse by the fiduciaries of employee pension plans. Underfunded pension plans, irresponsible fiduciaries, and a generally depressed economic environment contributed to the likelihood that many employees might be unable to obtain pension benefits even as the entire work forced aged and the fiscal solvency of the Social Security system became more and more precarious. (See generally, 29 U.S.C. section 1144; H.R. Rep. No. 807, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4670, 4678-9, 4680 ("House Report No. 807"); S. Rep. No. 383, 93rd Cong., 2d. Sess., reprinted in 1974 U.S. Code Cong. & Admin. News 4899 ("Senate Report No. 383").

ERISA's purpose was to establish standards of conduct, to set forth the

obligation of employee benefit plan fiduciaries and to provide "appropriate remedies, sanctions, and ready access to the federal courts" for the failure of a plan fiduciary to live up to its responsibilities under ERISA. (Public Law 93-0406, as codified at 29 U.S.C. section 1001-1461 (1982) section 2(b). As was explained by the United States Supreme Court in its recent decision in Massachusetts v. Morash,109 S.Ct. 1668, 104 L.Ed.2d 98 (1989):

> In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from the accumulated funds. [Citation.] To that

> end, it has established extensive reporting, disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator.

Thus, ERISA's purpose is to protect the beneficiary. Its purpose is not to protect the employer or the insurance company. A rule which would work to permit an insurer to interpret and apply an ambiguous policy term in its own favor, just as the appellate court did in this case, defeats ERISA's express purpose of protecting the beneficiary. Indeed, how better to protect the

beneficiary's interests than to apply a rule that ambiguities in the insurance contract must be interpreted in favor of the beneficiary?

This rule will not defeat the goal of uniformity in decisions in ERISA cases. Given the broad range of plans, policies and myriad benefits and coverages available under the plethora of group insurance policies available, there is simply no way to assure uniformity of benefits. Indeed, ERISA does not mandate uniformity of benefits. The goal, instead, should be uniformity of *interpretation*. That can best be achieved by adoption and application of uniform insurance contract construction rules.

Thus, irrespective of the particular policy provisions, as to

which there is no possibility of uniformity, the rules to be applied to interpret those provisions will be uniform.

As noted by the Ninth Circuit Court in Kunin, every state in the Union uses and applies the rule of *contra proferentum* in interpreting insurance policies. Accordingly, the rule of *contra proferentum* should be adopted and applied in all cases in which contract interpretation is necessary and a non-negotiated insurance contract is in issue.

However, as evidenced by the Ninth Circuit's own conflicting opinions in Kunin and Evans, the lower courts are in disarray and disagreement about what rules should be applied. It is therefore necessary that this honorable

Court examine this question and determine the proper rules of construction and interpretation to be applied to insurance policies issued to employee welfare benefit plans.

B.

WHERE THE CONTRACT TERMS SUPPORT THE APPLICATION OF VESTING OF BENEFITS, ERISA PROPERLY PERMITS SUCH VESTING IN THE CONTEXT OF MEDICAL INSURANCE BENEFITS UNDER AN EMPLOYEE WELFARE BENEFIT PLAN

Vesting of medical and health insurance benefits has been adopted as a rule of law in numerous states, including Arizona (Sparks v. Republic National Life Ins. Co., 132 Arizona 529,

647 P.2d 1127 (1982)), **New York** (Danzig v. Dikman, 78 A.D.2d 303, 434 N.Y.S.2d 217 (1980), aff'd., 53 N.Y.2d 926, 423 N.E.2d 402, 440 N.Y.S.2d 925 (1981)), **Oregon** (Myers v. Kitsap Physicians Services, 78 Wash.2d 286, 474 P.2d 109 (1970)), **Alabama** (Blue Cross-Blue Shield of Alabama v. Turner, 280 Ala. 714, 195 So.2d 807 (1967)), **Arkansas** (Branscum v. Service Life Ins. Co., 234 Ark. 463, 352 S.W.2d 586 (1962)), **Mississippi** (Brown v. Blue Cross & Blue Shield of Mississippi, 427 So.2d 139 (1983)), **Missouri** (Lutsky v. Blue Cross Hospital Service, Inc., 695 S.W.2d 870 (1985)), **Montana** (Wardlow v. Kalispell General Hospital, 164 Mont. 59, 518 P.2d 1164 (1974); Fassio v. Montana Physicians' Service, 170 Mont. 320, 553 P.2d 998 (1976)), **New Mexico** (Erwin v. Limited

Benefit Life Ins. Co., 70 N.M. 138, 371 P.2d 791, (1962)), and Texas (Washer v. Continental Casualty Co., 418 S.W.2d 900 (1967), and Fields v. Blue Shield of Calif., 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), reh'g denied October 21, 1985.

For example, in Myers v. Kitsap Physicians Services, 78 Wash.2d 286, 474 P.2d 109 (1970), the insured under a group health care services contract suffered a chronic kidney disorder which required hospital hemodialysis treatments. The health care services company modified the health care contract under which the plaintiff was covered to exclude chronic kidney disorder treatments from coverage. The Washington Supreme Court stated:

"'We therefore conclude that

the contract before us, when considered for the purpose of granting or rejecting plaintiff's claim for hemodialysis hospitalization benefits . . ., may reasonably be given more than one interpretation. Although the contract is a health service contract, one reasonable interpretation of its provisions would be grounded on the same legal principle applied generally in cases relating to health and accident policies, i.e., that plaintiff's rights under the contract became vested when medical treatment became necessary. Those rights being

vested, the subsequent termination of the policy which created the right did not terminate the vested right of the plaintiff to payment of services rendered and to be rendered. (Fields, supra, 163 Cal.App.3d at 588, 209 Cal.Rptr. at 791-792; emphasis added by Fields court.)'"

Adoption of the vesting rule in the context of ERISA plans as part of the federal common law comports with state law and helps effectuate the policy concerns underlying ERISA. Where an employer, as part of an ERISA welfare benefit plan, purchases an insurance policy and the employer, through mismanagement of funds or otherwise,

causes termination of the plan, the employee can at least be protected for existing conditions up to the policy limit.

In the court below, ALLSTATE argued that, even if the policy supported the application of the vesting doctrine, vesting could not be applied to an employee welfare benefit plan. ALLSTATE argued that while ERISA expressly provides for vesting of benefits under pension plans, no such provisions were included under the welfare benefit plan provisions. This, ALLSTATE concluded, requires a finding that no vesting of benefits is authorized under ERISA.

This argument is flawed. The fact that ERISA does not require vesting of benefits clearly does not justify the conclusion that it therefore precludes

vesting of benefits. Although ERISA is a comprehensive statute, in terms of disclosure and regulatory rules, it simply does not mandate the type or extent of employee welfare benefits which must be provided. Indeed, ERISA does not require that any benefits be provided at all. It simply steps in to make sure that, when benefits are provided, they are provided in such a way as to protect the best interests of the beneficiaries.

By its very nature, the provision of employee benefits, especially medical insurance benefits, varies from employer to employer. ERISA does not require uniformity of benefits. Rather, the benefits are determined by the terms of the individual plan and/or the insurance policy purchased to provide the plan

benefits. Thus, ERISA's provisions are not determinative of whether vesting of benefits is applicable. Instead, the individual contract is determinative of that issue.

The same argument presented by ALLSTATE in this case was raised by the defendant in International Resources, Inc. v. New York Life, 950 F.2d 294 (6th Cir. 1991):

> "Finally, we come to a matter not addressed by the district court though raised by the parties on appeal. That is, whether or not the plaintiffs' rights have "vested" for the purpose of bringing the instant claims. We have held that pension plans are subject to statutory vesting

requirements under 29 U.S.C. §1053, although welfare plans are not. Armistead v. Vernitron, 944 F.2d 1287, 1297 (6th Cir. 1991). New York Life would have us believe that a welfare plan will never vest, because there is no statutory vesting requirement, or that such a welfare plan can only vest if it has explicit provisions providing for vesting in the plan documents. New York Life, however, misstates the law of In re White Farm Equipment Co., 788 F.2d 1186, 1193 (6th Cir. 1986). There, we found that we will not construe ERISA as providing a mandatory

point for welfare benefits to vest. Nonetheless, a court may look to the parties' intent to determine when vesting should occur. Such intent may be demonstrated by 'agreement or by private design.' Id. See also Armistead, at 1297-98. There may be sufficient evidence for the district court to find plaintiffs' claims have vested." (International Resources, supra, 950 F.2d at 301.)

As determined by the International Resources court, medical benefits may vest even though there are no mandatory vesting requirements under ERISA itself

and even where there is no express vesting provision in the policy. Thus, the issue of whether the benefits vest becomes inextricably intertwined with the determination of which rules of contract construction are to be applied. If standard contract rules, where ambiguity does not penalize the drafter, are applied, there may be no vesting. If, however, the adhesion contract rules normally applied in the insurance policy context are utilized, the policy at issue in this case clearly requires vesting of benefits.

It is not evident on the face of the appellate court's opinion what rule of construction it applied. However, the court determined that because the "Eligible Expenses" provision and the termination provision could be

harmonized and reasonably construed to preclude vesting, there would be no vesting. However, this conclusion ignores the fact that those provisions could also be harmonized and reasonably construed to provide vesting. If the adhesion rules of contract construction are applied to the insurance policy issued to an ERISA employee welfare benefit plan, MARSH is entitled to his vested benefits under the ALLSTATE policy and the appellate court erred.

Again, these are issues that will affect millions of Americans. There is already a crisis in the provision of health care to Americans. Every case which fails to protect the interests of the insured in an underwritten employee welfare benefit plan furthers the crises and sacrifices the health of covered

Americans to the interests of insurance companies garnering excessive profits. These issues must be addressed.

C.

HAVING FAILED TO NOTIFY THE BENEFICIARIES OF THE PLAN THAT CONVERSION BENEFITS WERE SIGNIFICANTLY REDUCED FROM THE GROUP POLICY, ALLSTATE IS REQUIRED TO PROVIDE EQUIVALENT BENEFITS UNDER THE CONVERSION POLICY

Another issue derivative of the issue as to which contract construction rules should apply is the question of what level of benefits MARSH was entitled to when the underlying group policy terminated and he sought to

purchase conversion coverage offered as an express benefit under the terms of the group policy.

The ALLSTATE policy at issue in this action expressly provides that, upon termination of coverage under the policy, the insured may apply for, and purchase, an individual conversion policy. When MARSH's father, who was the president of the company and the person responsible for choosing the insurance coverage, first obtained coverage under the ALLSTATE policy, the policy was silent as to the extent or amount of benefits to be provided under the conversion policy. Obviously, the extent of or the amount of conversion benefits would be important to any policyholder when deciding whether to procure a contract of insurance. The

absence of information concerning the conversion benefits when the policy is purchased is critical, since most policyholders will have no opportunity to shop the policy when the conversion rights are later needed.

When MARSH needed to convert from a group to an individual policy, he was virtually uninsurable under any other plan as a result of his catastrophic injury and disability. Thus, although MARSH's father may have been informed of the rights MARSH had under the conversion policy <u>after</u> the termination of the ALLSTATE group policy, he was, at that time, a captive purchaser who could only decide to take the conversion policy in the form offered by ALLSTATE or go completely uninsured. When the information concerning the rights and

benefits available under the conversion policy was finally made known to MARSH and his parents, that information was useless to them since MARSH had no alternative but to take the conversion policy despite its limited offerings.

A simple caveat placed within the policy language indicating that the rights under the conversion policy were substantially less than the rights under the group policy would have clarified the benefits offered under the conversion policy at the outset. In Sur v. Glidden-Durkee, a division of S.C.M. Corp. 681 F.2d 490 (7th Cir. 1982) (cited by defendant ALLSTATE in its Motion for Summary Judgment), the court was presented with facts substantially similar to those presented in the instant action. There, the policy was

silent as to the benefits afforded under the conversion policy stating only that the conversion policy was "subject to established rules". The Sur court stated:

> "This provision does not affirmatively state that the conversion policy will carry the same coverage as the group policy; but that fact alone does not make the provision not misleading. We must examine the provision in its entirety, and in the context in which it appears, to determine whether a rational trier of fact could find it misleading." Id.

In the instant action, the

conversion policy merely made reference to the benefits required by applicable law. Yet, reference to applicable law is virtually meaningless to a policyholder who lacks the legal sophistication and acumen that the drafter of the ALLSTATE policy possessed. Additionally, once the policy is issued to an employer, the question becomes whether individual state law regarding conversion rights constitute the "applicable law" or whether, under ERISA, federal law controls the content of the conversion policy. Naturally, absent any notice to the contrary in the policy, the insured would most reasonably expect that the same level of coverage as provided in the group policy would be provided in the conversion policy. Applicable law

does not change that result.

If it is determined that solely federal law is controlling, there are no limitations, either maximum or minimum on the type or extent of benefits which must be provided. Alternatively, state law provisions most commonly provide minimum benefits which must be provided but do not specify any maximum benefit level. Thus, under either federal or state law, the insured would reasonably expect the same level of coverage as provided in the group policy, absent some disclosure in the policy.

It is not argued that it was necessary for ALLSTATE to spell out in detail the benefits available under the conversion policy. However, ALLSTATE should have at least warned the policyholder that the benefits available

under the conversion policy would be substantially less than benefits available under the previous group policy.

MARSH detrimentally relied on the implicit promise of equivalent benefits. MARSH's father left his employment with Universal Broadcasters and elected to invoke his COBRA rights to continue coverage under the ALLSTATE policy for an 18-month period. However, prior to the expiration of that 18-month period, MARSH's father, believing that the conversion policy provided substantially similar benefits, terminated his COBRA participation and elected to proceed under the conversion policy. Had MARSH's father known that the conversion policy offered such drastically reduced benefits he simply would not have

surrendered his substantial COBRA rights.

Since ALLSTATE failed to inform the plan beneficiaries that the benefits available under a conversion policy would be substantially less than those under the group policy, ALLSTATE should provide substantially similar benefits under the conversion policy. Anything less constitutes a fraudulent business practice which should not be condoned by this Court.

CONCLUSION

This Court's review and determination of the proper and appropriate rules of construction to be applied to the interpretation and application of insurance policies issued to employee welfare benefit plans is vital. Although uniform benefits are not required or mandated under ERISA, common sense requires that a uniform system of policy interpretation be established. That determination should be made by this Court so that American citizens, who exchange the sweat of

their brow for the insurance protections provided by their employers, can be protected and assured of the benefits they work so hard to obtain.

Respectfully submitted,

Dated this 14th day of June, 1993 at Claremont, California.

SHERNOFF, BIDART & DARRAS

By: _____
WILLIAM M. SHERNOFF
Attorneys for Plaintiff and Petitioner

APPENDIX

TAB	DOCUMENT
A	MEMORANDUM ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT
B	ORDER DENYING PETITION FOR REHEARING BY THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT
C	29 U.S.C. SECTION 1001, ET SEQ.
D	ORDER GRANTING PRELIMINARY INJUNCTION OF THE UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
E	ORDER ON SUMMARY JUDGMENT OF THE UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA

APPENDIX A

No. 90-56143

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

MEMORANDUM*

---

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

Appeal from the United States District Court for the Central District of California, Robert C. Bonner, District Judge, Presiding, Argued and Submitted May 8, 1991, Pasadena California

Before: BEEZER, HALL, and TROTT, Circuit Judges.

Appellant Jonathan Marsh appeals from the district court's grant of summary judgment to Appellee Allstate in March's suit to obtain continuing medical benefits under a policy terminated by Allstate. The district court had jurisdiction under 28 U.S.C. §1331 and 29 U.S.C. §1132(e). This court has jurisdiction pursuant to 28 U.S.C. §1291. We affirm.

I

In Evans v. Safeco Life Ins. Co., 916 F.2d 1437, 1441 (9th Cir. 1990), this court held that the interpretation of ERISA insurance policies is governed

by a "uniform federal common law." In developing a federal common law to govern ERISA suits, federal courts should borrow "from state law where appropriate, and [be] guided by the policies expressed in ERISA and other federal labor laws." Scott v. Gulf Oil Corp., 754 F.2d 1499, 1502 (9th Cir. 1985).

II

This court reviews a district court's grant of summary judgment de novo. International Brotherhood of Electrical Workers, Local 47 v. Southern Cal. Edison Co., 880 F.2d 104, 105 (9th Cir. 1989). In doing so, it must determine whether, viewing the evidence in the light most favorable to the party against whom summary judgment has been

granted, there is any issue of material fact and whether the moving party is entitled to judgment as a matter of law. Arizona Laborers Local 395 Health and Welfare Trust Fund v. Conquer Cartage Co., 753 F.2d 1513, 1515 (9th Cir. 1985). "When the meaning of an agreement is ambiguous on its face and contrary inferences as to intent are possible, an issue of material fact exists for which summary judgment ordinarily is inappropriate." International Brotherhood of Electrical Workers, 880 F.2d at 107 (citing Arizona Laborers, 753 F.2d at 1517-18).

III

In determining whether or not an insurance contract is ambiguous, this court will interpret its terms "'in an

ordinary and popular sense as would a [person] of average intelligence and experience.'" Evans, 916 F.2d at 1441 (quoting Allstate Insurance Co. v. Ellison, 757 F.2d 1042, 1044, (9th Cir. 1985)). The court should "examine[] the contract as a whole and if, on the face of the contract, two reasonable and fair interpretations are possible, an ambiguity exists." Evanston Insurance Company v. Fred A. Tucker & Co., Inc., 872 F.2d 278, 279 (9th Cir. 1979). The court will "'not create ambiguity where none exists.'" Evans, 916 F.2d at 1441. And if "'a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.'" Id.

There is no doubt that there is a reasonable interpretation of the Policy that favors Allstate. The Policy includes a broad description of the expenses it covers that cannot be interpreted to include expenses incurred after the Policy is terminated. It states: "The Medical Benefit is paid for Eligible Expense [sic] incurred for an Injury or Sickness while insured." And it defines an "Eligible Expense" as an expense "incurred for an Injury or Sickness while insured." Both provisions plainly refer to <u>expenses incurred</u> while insured, not <u>expenses arising from a sickness incurred</u> while insured. This reading is supported by the clause providing that an "'Expense' is deemed incurred on the date the

service or supply is furnished." If the Policy covered expenses incurred after termination, there would be no reason to specify the date on which an expense is incurred.

This interpretation is consistent with the Policy's "EXTENSION OF BENEFITS" provision. That provision sets forth limited circumstances under which a person may obtain benefits under the Policy even though the policy has been terminated. It states that Allstate will pay the Medical Benefit after the person's insurance ends if the person is totally disabled at the time the Policy is terminated and at the time the expense is incurred, the expense is directly related to the disability, and the expense is incurred within one year

of the termination. If, as Marsh claims, the Policy vested benefits, there would be no reason to include the "EXTENSION" provision because every expense it covers would be covered by vesting. In other words, the provision would be superfluous.

Considered together, these provisions would appear to preclude vesting. But Marsh points to another provision of the Policy that he claims vested his rights to benefits for any illness she contracted prior to the termination of the Policy. At the very least, he argues, this provisions cast doubt over those provisions of the Policy that preclude vesting, creating an ambiguity.

Marsh points to the provision in

the section of the Policy entitled "TERMINATION OF INSURANCE." It states: "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force." Marsh concludes that "loss" must refer to a sickness or injury that occurred while the policy was in effect. But Allstate responds that "loss" refers not to sickness but to "eligible expense." Read in isolation, "loss" could reasonably refer to either "sickness" or "expense"; the term is itself ambiguous. But precisely because of its ambiguity, it does not conflict with the provisions that preclude vesting. Read in light of the Policy's express limitation on the payment of medical benefits and the "EXTENDED COVERAGE" provision, the

ambiguity disappears and it becomes clear that "loss" refers to "expense". Thus the "TERMINATION" provision does not conflict with other portions of the Policy and does not render the Policy ambiguous.

IV

Finally, we conclude that nothing in the Policy implies that Marsh should receive the same benefits under the conversion policy as he did under the group policy. Marsh has pointed to nothing in the Policy that would have caused a reasonable person to draw such a conclusion. Nor has he offered any evidence that he held such a belief and relied on it.

V

Because we conclude that the Policy

unambiguously precludes the vesting of benefits, the decision of the district court is AFFIRMED.

APPENDIX B

No. 90-56143

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

ORDER

Before: BEEZER, HALL and TROTT, Circuit Judges

The panel has voted to deny appellant's petition for rehearing and to reject the suggestion for rehearing en banc.

The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing is DENIED and the suggestion for rehearing en banc is REJECTED.

APPENDIX C

29 U.S.C. section 1001:

CONGRESSIONAL FINDINGS AND DECLARATION OF POLICY

(a) **Benefit plans as affecting interstate commerce and the Federal taxing power**

The Congress finds that the growth in size, scope and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment

and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that

disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees

and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) **Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries**

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of

participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts.

c. **Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance**

It is hereby further declared to be the policy of this chapter to protect

interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.

APPENDIX D

No. CV 90-2145 RB (Ex)

in the

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant

ORDER GRANTING PRELIMINARY

INJUNCTION

This matter came to be heard upon Plaintiff Jonathan Marsh, a minor, by and through his Guardian ad litem, Sharon Marsh's Motion for Preliminary Injunction, as supported by the Complaint, the other pleadings, memoranda, declarations and exhibits filed in this case. The Court, having considered the pleadings and documents filed in this matter and the arguments of counsel, makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. Plaintiff JONATHAN MARSH, the son of RICHARD V. MARSH and SHARON MARSH, was born September 29, 1978. On or about October 28, 1982, plaintiff suffered anoxic brain damage as the result of a

swimming pool drowning accident that has left plaintiff in a persistent vegetative stated, totally disabled, and dependet upon home health nurses to provide him with care, treatment and medical assistance.

2. At the time of the plaintiff's drowning accident, plaintiff was insured as a dependent of his father, RICHARD MARSH.

3. RICHARD MARSH is an employee of MARSH BROADCASTING, which company had joined in association with Universal Broadcasting Corporation ("UNIVERSAL") to procure health insurance for its employees.

4. Universal procured major medical and health insurance for its member-employers and their employees from

Equinet Small Group Network Trust, the policyholder of insurance underwritten by defendant Allstate Life Insurance Company of New York ("ALLSTATE").

5. Previously, similar policies of insurance had been underwritten by The Equitable Assurance Society of the United States and The Travelers Insurance Company.

6. Effective April 10, 1986, Allstate Life Insurance Company of New York ("ALLSTATE") assumed underwriting of the group plan through which plaintiff was insured, and continued to provide plaintiff coverage through May 1, 1989 when Allstate terminated the group coverage.

7. Pursuant to the "EXTENSION OF BENEFIT" provision, Allstate extended

benefits available under the group insurance policy for one year from the date of termination through expiration on May 1, 1990.

8. Allstate has offered to extend plaintiff an individual conversion policy, see Exhibit "C" at 24a, and although such benefits are not clearly defined, they are less comprehensive and are severely limited in medical coverage as compared with the benefits currently provided by Allstate through the extension of benefits policy.

10. [sic] Under the heading of TERMINATION OF INSURANCE: Dependents' Insurance, the subject insurance policy provides that "[t]he end of insurance will not affect any claim made for a loss that took place while the insurance

was in force. [sic] See Exhibit "C" at 8a of Plaintiff's Application for Temporary Restraining Order.

11. The financial inability of plaintiff's parents to meet the expenses incurred by plaintiff's health care costs, estimated at $325,000 annually, threatens the discontinuation of plaintiff's major medical and hospitalization coverage and individual nursing home care. See Declaration of Sharon Marsh, appended to Application for Temporary Restraining Order.

12. Without constant diagnostic monitoring, "round-the-clock" treatment, and supervision by skilled health care professionals, the loss of individual home nursing care risks endangering the plaintiff's physical and mental

condition. See Declaration of Carol Walker, M.D., appended to Application for Temporary Restraining Order.

CONCLUSIONS OF LAW

This Court has jurisdiction over the matter as plaintiff is a dependent under a group insurance policy issued to the employer of plaintiff's father. The group insurance policy is a benefit pursuant to a "benefit plan" as defined in 29 U.S.C. 1001, et seq., the Employee Retirement Income Security Act ("ERISA") and as interpreted by the United States Supreme Court in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987).

Plaintiff's application for a temporary injunction demonstrates that there are serious questions going to the

merits and that the balance of hardship tips sharply in his favor. Sierra Club v. March, 815 F.2d 1376, 1382 (9th Cir. 1987). See also Regents of the Univ. of Calif v. ABC, Inc., 747 F.2d 511, 515 (9th Cir. 1984) ("the greater the relative hardship to the moving party, the less probability of success must be shown").

Notwithstanding the applicability or breadth of ERISA's preemption (29 U.S.C. §514(a), in resolving claims that implicate a group health policy for employee welfare benefit plans, general principles of contract construction require that ambiguities in insurance contracts be construed against the insurer. Kunin v. Benefit Trust Life Insurance Co., 90 Daily Journal DAR

3073, 3076 (March 22, 1990).

The plain reading of the Allstate Policy language which provides that "[t]he end of insurance will not affect any claims made for loss that took place while the insurance was in force" is, at best, ambiguous and must be resolved against Allstate. [emphasis added]. See Gray v. Zurich Insurance Co., 65 Cal.2d 263, 271-72 (1966) (a policy provision is ambiguous when there are two or more reasonable interpretations or constructions of the policy language).

Reasonable interpretation of the above cited language means that termination of the insurance policy would not preclude recovery on claims arising out of a loss which occurred

during the pendency of the policy. Thus, in the case at bar, Allstate's termination of coverage in May 1989, would not affect plaintiff's rights to continue to receive medical care for the pre-existing medical condition from which plaintiff suffered consistent with the care he had been receiving while the policy was in force.

Allstate urges that the language in question states that nothing more than "expenses" incurred during the time the insurance policy is in force will be reimbursed even after termination. The Court is not persuaded to read the clause to effectuate that limitation. Specifically, the policy language with regard to the contested provision uses the term "loss." The dictionary

definition of the term "loss" as applied in insurance agreements means an injury that is the basis for a claim under the terms of the policy. Webster's New World Dictionary 799 (3d ed. 1988). Because the basis for plaintiff's claim is the injury sustained while the policy was in force, an insured could reasonably expect that continuous disability benefits relating to that loss are to be covered even after the termination of the policy.

The Court bases its conclusion without reaching the question whether the right to receive benefits "vests" at time of disability (and cannot be divested by subsequent termination of the policy) is applicable to the instant case. Instead, the Court's ruling is

based on the well-settled view that ambiguities in an insurance contract must be interpreted in the light most favorable to the insured, and that the language of an insurance contract should in fact 'be interpreted in accordance with the way it would be understood by the average man purchasing insurance.'" (Fields v. Blue Shield of California, 163 Cal.App.3d 570, 588 (1985).

Pending the trial in this matter, the Court ORDERS that ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK is prohibited from terminating and/or withholding and/or decreasing the policy benefits payable to the insured JONATHAN MARSH, under Group Policy No. 208748.

Pursuant to Fed. R. of Civ. Pr. 56(c), this Preliminary Injunction Order

shall issue and become effective upon the posting of security by plaintiff in the sum of $125,000.

Trial in this matter is set for September 25, 1990 at 9:30 a.m. Pretrial conference will be held September 17, 1990 at 3:00 p.m. The parties will have until September 17, 1990 to complete discovery in this action.

IT IS SO ORDERED

DATED: May 9, 1990

ROBERT C. BONNER
UNITED STATES DISTRICT JUDGE

APPENDIX E

No. 90-2145 RB (Ex)

in the

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JONATHAN MARSH,

a minor, by and through his

Guardian Ad Litem, Sharon Marsh

Plaintiff-Appellant

vs.

ALLSTATE LIFE INSURANCE COMPANY

OF NEW YORK,

Defendant-Appellee

MEMORANDUM OF DECISION AND ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT, GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT AND DISSOLVING PRELIMINARY INJUNCTION ORDER

Introduction

On May 9, 1990 this Court granted a preliminary injunction enjoining Allstate Life Insurance Company of New York from terminating, withholding, or decreasing the policy benefits payable to the insured Jonathan Marsh, under Group Policy No. 208748. See Order Granting Preliminary Injunction filed May 9, 1990. Concurrent with the hearing setting security for the Preliminary Injunction, the Court also calendared these cross-motions for summary judgment to full adjudicate the rights and liabilities of the parties to this dispute.

This Court, having heard oral argument in this matter on July 30, 1990 and having considered the memoranda and

evidence submitted by counsel, concludes Allstate is entitled to summary judgment in its favor and plaintiff's motion for summary judgment is denied. Dissolution of the Preliminary Injunction Order, which has remained in effect since the July 30, 1990 hearing, is stayed for thirty (30) days from the entry of this Order.

Factual Background

Plaintiff, the dependent son of Richard V. Marsh, an employee of Marsh Broadcasting, suffered a near-drowning accident in October of 1982 that rendered him totally disabled. He is in a persistent vegetative state and dependent upon home health nurses to provide him with care, treatment, and

medical assistance. The plaintiff, a minor represented by his Guardian ad litem, his mother Sharon Marsh. At all times relevant to this action, Richard Marsh was an employee of Marsh Broadcasting, a company which had joined in association with defendant Universal Broadcasting Corporation to procure health insurance for its employees. Universal Broadcasting Corporation, in turn, had procured insurance for the employees of its members from defendant Equinet Small Group Network Trust.

At the time of plaintiff's accident in 1982, he was insured under a group policy issued by The Equitable Life Insurance. Subsequently, Equinet replaced the Equitable policy with Travelers, which itself was later

replaced with Allstate, effective April 10, 1986. However, Allstate did not actually begin providing benefits to plaintiff until January 1, 1988, because plaintiff was receiving benefits under an extension of benefits provision of the predecessor carrier's policy.

Allstate's liability for coverage to plaintiff extends to reimbursing medical expenses incurred while its Group Policy is in force. In addition, where a pre-existing condition is involved, Allstate pays benefits for a pre-existing condition that was covered while the prior policy was in force, but those benefits are also limited to medical expenses incurred during the period the Allstate Group Policy is in force. See Allstate Policy, at 20a and

29a.

Richard Marsh terminated coverage for himself and his dependents under the Allstate Group Policy on April 30, 1988 and elected to receive continuation benefits under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, Title 29 U.S.C. sections 1161-1168) until April 30, 1989 when that coverage was terminated by Mr. Marsh.[1]

Upon termination of plaintiff's COBRA coverage, Allstate, beginning on May 1, 1989, provided benefits to plaintiff under the "Extension of Benefits" provision of the Group Policy (18a).[2] The extension expired on May 1, 1990.

Mr. Marsh has elected to purchase an individual conversion policy, but

these benefits are less comprehensive than the benefits provided by Allstate under the group plan.[3]

When an insured terminates employment, as did Mr. Marsh, he is provided with a "Notice of Conversion Privilege for Group Medical Insurance," which, in part, states that "this conversion coverage is different from the benefits you had under the group plan." Exhibit A, appended to Allstate's moving papers.

Discussion

1. "Vesting" does not apply to Plaintiff's right to coverage for medical expense benefits under the Allstate Group Policy.

Plaintiff argues that he as a "vested" right to reimbursement of expenses incurred as a result of his

continued treatment for injuries sustained as a result of the 1982 accident. Plaintiff has not cited any authority that has ever incorporated the California state law concept of "vesting" into the ERISA context. However, this Court need not decide whether as a matter of federal common law vesting should ever apply under ERISA, because this doctrine does not help plaintiff under the facts and circumstances of the Allstate policy.

The general rule of vesting provides that "[a] valid cancellation of a group policy does not have the effect of releasing the insurer from liability which accrued prior thereto by reason of the happening of the contingency insured against. In other words, once liability

has attached under a group policy -- that is, after the happening of the event insured against -- cancellation of the policy is ineffective to preclude recovery by the beneficiary as provided by the original policy. This rule does not apply where there is an express provision in the policy to the contrary." See Annotation, 68 A.L.R.d 248, section 17 at 279 (Group Policy - Coverage Termination (1959)).

The concept of vesting is not germane to plaintiff's claim to continued reimbursement under Allstate's policy for two reasons. First, vesting is predicated on a "happening", that is, an "occurrence." Typically, vesting arises in an accidents or casualty policy. Allstate's duty to plaintiff,

however, derives from a "Medical Expense Benefits" policy where the triggering "event" is the accrual of a medical expense, e.g., for home care treatment.

Under medical expense insurance policies, an insured's right to benefits does not "vest" at the occurrence of an injury. Indeed, it would be illogical to hold plaintiff's rights "vested" with Allstate in 1982 (date of the accident) when, in point of fact, Allstate was not even the carrier at the time of plaintiff's accident. See Blue Cross of Florida v. Dysart, 340 So.2d 970 (Fla.App.2d Dist. 1976) (an extension of benefits for treatment related to injuries sustained while plaintiff was covered by Blue Cross did not apply to a policy of medical expenses insurance,

although it might apply to a policy of accident insurance, because accident policies generally contemplate converge for all expenses incurred as a result of an accident occurring within the policy period). Bartulis v. Metropolitian Life Insurance Company, 72 Ill.App.2d 267 (4th Dist. 1966) also resolved a similar type of duration of coverage issue on the basis of the insurance policy in question. The court held that the group hospitalization insurer was not liable for surgery after the policy period, although the injury occurred during the period of coverage, because the coverage was not for injuries during the policy period but for expenses incurred during the policy period.

> It seems crystal clear that the coverage provided was for

> confinement as a patient in a hospital and surgery performed while the policy was in force. Neither event occurred during the life of the policy. Neither in such provisions nor elsewhere in the policy is there language suggesting that the policy could or should be read as providing coverage for hospitalization or surgery resulting from injuries while the policy was in force. To so read this policy is to annex to it coverage neither specifically stated nor reasonably implied.

Id. at 226.

Second, the Allstate policy itself expressly limits benefits for expenses incurred while coverage is in force. In this regard, the "Medical Benefit" section provides payment for an "eligible expense incurred for an Injury or Sickness while insured" (12a), and the "Termination of Insurance" section provides that the end of insurance will

not be used to deny coverage for "a loss that took place while the insurance was in force" (7a). The Allstate policy, consequently, does not provide benefits for expenses incurred after termination of coverage, excepting the one-year post-termination period during which time the beneficiary is entitled to extended benefits. See Cohen v. Northwestern National Life Insurance, 124 Ill.App.2d 15 (1st Dist. 1970) (insurer was not held liable for charges incurred by the plaintiff's covered dependent after coverage terminated, even though the charges related to a condition diagnosed prior to cancellation of the group policy because policy provided coverage for medical expenses "if while insured under the

policy").

Finally, plaintiff's reliance on Fields v. Blue Shield of California, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (Cal.App.4th Dist. 1985) is misplaced. In Fields, the group health contract provided for a "lifetime maximum benefit payable for treatment of nervous and mental illness of $50,000." While the contract was still in force, it was modified to exclude coverage for psychological treatment that was used to obtain credit "toward earning degree." Fields, a physician who began psychoanalysis based on being diagnosed as a neurotic, decided to become a psychotherapist, and continued receiving psychoanalysis as part of his training requirement. Blue Cross invoked the

"furtherance of education" exclusion. In finding Blue Cross liable for reimbursement of expenses, the court held that the original contract "evidenced a clear contractual intent of Blue Cross to provide for nervous or mental illness which might persist for the lifetime of an insured" once treatment for a specific illness began. Id. at 585. Those benefits, up to the $50,000 lifetime maximum, became vested as matter of contractual right under the plan at issue. In addition, the court found the notice of modification provision was "clearly ambiguous" and in conflict with the original contract's unequivocal language permitting a lifetime maximum $50,000 grant. Id. at 584.

The Fields holding was based principally on the insurer's unilateral modification of the policy, a modification that contradicted the terms of the insured's insurance contract guaranteeing that "No such modification or termination will affect adversely any benefit for a covered service." Given the modification's ambiguity, the court invoked the settled view that "where a health insurance contract is susceptible to different reasonable constructions, it is ambiguous -- the insurance policy is to be strictly construed against the insurer. (Civ. Code section 1654)." Fields, supra, at 584-85.

The case at bar is unlike Fields where "modifications" to the scope of coverage, made while the policy was in

force, had the effect of reducing plaintiff's benefits. Dr. Fields had been and remained covered by the insurer, Blue Cross, at the time benefits were withheld; whereas, in the instant case, Mr. Marsh voluntarily terminated coverage and, therefore, under the terms of the policy, his dependent's rights to recover medical expense benefits.[4]

2. Kunin supplies the rule of contra proferentum in ERISA actions.

Allstate's Group Insurance Policy, issued to the employer of plaintiff's father, confers benefits pursuant to a "benefit plan" as defined in Title 29 U.S.C. 1001, et seq., the Employee Retirement Income Security Act ("ERISA") and as interpreted by the U. S. Supreme Court in Pilot Life Insurance Co. v

Dedeaux, 481 U.S. 41 (1987). Notwithstanding the applicability or breadth of ERISA's preemption (29 U.S.C. section 514(a)) in resolving claims that implicate a group health policy, general principles of contract construction mandate that "ambiguities in insurance contracts must be construed against the insurer." Kunin v. Benefit Trust Life Insurance Co., 90 Los Angeles Daily Journal D.A.R. 8450 (No. 88-6573 July 30, 1990). The Ninth Circuit unequivocally adopted this view, holding that the rule of contra proferentum applies to a group health and medical policy governed by ERISA.[5]

A typical statement of the rule, as explained in Kunin, is that if, after applying the normal principles of

contractual construction,

> the insurance contract is fairly susceptible of two different interpretations, another rule of construction will be applied: the interpretation that is most favorable to the insured will be adopted. The rule is based upon the principle of contract construction that when one party is responsible for the drafting of an instrument, absent evidence indicating the intention of the parties, any ambiguity will be resolved against the drafter.

Id. at 8450, citing A. Windt, Insurance Claims and Disputes section 6.02, at 281-82 (footnote omitted).

However, the ambiguity must affect the determination whether coverage should be denied. Where resolution of the ambiguity at issue would not arguably permit coverage under either of the two reasonable interpretations, the

insured cannot avail himself of this rule of construction.

3. The Allstate Group Policy does not provide benefits for plaintiff's medical expenses incurred after termination of the policy.

At the preliminary injunction proceeding, this Court found that the Allstate Policy language relating to the "Termination of Insurance" section (8a) -- "[t]he end of insurance will not affect any claim made for loss that took place while the insurance was in force" -- is ambiguous. Nowhere in the policy, for instance, including the extensive "Definitions" section, is te term "loss" defined.[6] There might be room for disagreement in certain

circumstances as to the limiting effect of the term "loss." However, for purposes of adjudicating the plaintiff's rights against Allstate in this case, the Court need not resolve that construction here. Notwithstanding the ambiguity of that clause, it is clear that plaintiff's rights are only ro reimbursement for a covered loss arising while the policy was in effect. Regardless of whether the term "loss" is construed to refer to the plaintiff's 1982 accident or his continuing medical expenses, neither occurred while the Allstate policy was in effect.

On the one hand, Allstate apparently claims "loss" refers to the round-the-clock home health care and medical expenses[7] incurred while the

policy is in force, that is, through April 30, 1990, including the one-year extension of benefits period. If this construction is operative, then, plaintiff is not covered for expenses incurred beyond the policy's termination, that is, for a loss (read expense) that did not take place <u>while</u> the insurance was in force.

Alternatively, the term "loss" can refer to plaintiff's 1982 swimming pool accident, but since that loss did not take place "while [Allstate] insurance was in force" -- indeed, it took place about 3 1/2 years before Allstate became the group carrier -- Allstate cannot be held liable to plaintiff under that usage of "loss." Plaintiff does not enjoy a "vested" right against Allstate

to coverage for continued treatment for injuries sustained as a result of an accident, for at the time of the 1982 accident Allstate was not on the risk. See Parrish v. National General Insurance Company, 731 S.W.2d 547 (Tenn. Ct. of App. 1987).

Finally, the plaintiff claims entitlement to continued coverage from Allstate based on the "Transfer of Insurers" section (20a). This section is relevant where, as here, the Employer's plan replaces another group medical expense plan. Allstate agrees to pay benefits for a pre-existing condition that was covered under the immediately prior policy of the insured, but limits benefits to the lesser amount of 1) the benefits of the Allstate plan

or 2) the benefits of the plan being replaced.

The purpose of this provision is to incorporate Insurance Code section 10128.3, ensuring that when one group policy replaces the immediately preceding group policy, the successor insurer may not withhold benefits for pre-existing conditions covered by the prior carrier, which, otherwise the successor insurer typically would exclude. It does not, however, mean that Allstate assumes or succeeds to an unlimited coverage obligation after terminating and cessation of premium payments for a condition that may have accrued with respect to the prior carrier. That is, benefits that might or might not arguably have been "vested"

under a predecessor policy are not transferred from one insurance carrier to another on the basis of this provision.

4. Plaintiff is not entitled to the Same Level of Benefits under the Conversion Policy as provided under the Group Policy.

Plaintiff contends that he is entitled to the same level and extent of benefits under the Conversion Policy (24a) as he received pursuant to the Group Policy. As a matter of statutory requirement, Insurance Code sections 12670 and 12684 ensure that conversion policies satisfy a certain level of "minimum benefits" with which Allstate has complied.

Plaintiff's father, Mr. Marsh, asserts that he was under the impression his son would receive the comparable benefits as provided under the group plan, because the policy stated "the form, benefits provided, premiums and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." (24a) Allstate provided Mr. Marsh with detailed information regarding the amount of conversion coverage available at his request. Decl. of Elizabeth Townsend, appended to Allstate's moving papers. In response, plaintiff has not provided any rebuttal evidence to support the [sic] Mr. Marsh's suggestion that he was misled into thinking the individual policy would ba as

comprehensive as the group policy. Indeed, Mr. Marsh's belief that expenses incurred on behalf of his son would remain covered was based on his understanding of the "Termination of Insurance" clause. Marsh Decl. at para. 4 & 5, appended to Plaintiff's moving papers. Accordingly, it appears that Mr. Marsh was not even relying on the "Transfer of Insurers" section when he elected to terminate his COBRA coverage, and opted for the individual conversion package of benefits.

In any event, the "Transfer of Insurers" section does not operate to "vest" coverage as against the successor carrier for claims concerning a pre-existing condition that arose during the term of a prior carrier's policy.

Conclusion

Based on the foregoing reasons, IT IS ORDERED that Allstate's motion for summary judgment is granted and plaintiff's motion for summary judgment is denied.

IT IS FURTHER ORDERED that the Preliminary Injunction Order shall be dissolved effective thirty (30) days from the entry of this Order.

Counsel for Allstate is directed to lodge within ten (10) days from the entry of this Order a proposed form of judgment.

IT IS SO ORDERED

DATED: AUGUST 10, 1990

ROBERT C. BONNER
UNITED STATES DISTRICT JUDGE

1. It appears Mr. Marsh was entitled to continuation of benefits under COBRA for 18 months post-termination, that is, until October 30, 1989. Title 29 U.S.C. section 1162 (individual may elect up to 18 months of COBRA continuation coverage).

2. The "Extension of Benefit" section provides that Allstate will pay the Medical Benefit after a person's insurance ends if, inter alia; 1) the person is totally disabled on the day the insurance ends and 2) the expense is incurred within 12 months after the day insurance ends. These conditions are satisfied in the instant case.

3. The Group Policy provides that: "A person whose medical Expense Insurance ends may be eligible to buy health insurance coverage from us. . . The form, benefits provided, premium and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." (24a) of the Group Policy.

4. In fact, Fields observes that courts which have declined to invoke the doctrine of "vesting" involved insurance policies which, as in the case a bar, "had been terminated before the insured incurred the medical expenses, before the vesting occurred." Id. at n. 7. This reasoning undermines plaintiff's view that benefits for medical expenses incurred after the Allstate policy

terminated had already "vested."

5. However, Kunin's amended opinion cannot be read to suggest, as plaintiff, urges, that California law regarding vesting, even if applicable to the facts at bar, applied to ERISA actions. As Kunin stated, "Of course, neither the law of California nor that of any other state is applicable here of its own force." And, although the opinion noted that "State law can sometimes control [ERISA] controversies," id. at 8450, the panel specifically declined to incorporate any state of California rule of construction into federal common law, because it explicitly held that the contra proferentum rule is "followed in all fifty states and the District of Columbia." Id.

6. The only other occasion where the term "loss" appears in the Accidental Death and Dismemberment Benefit section (10a) which is "For Employees Only." It provides for insurance against a loss of life or limb that results from an accident that takes place while insured by this benefit and within 90 days after the accident. The usage here supports the position that "loss" refers to the event or triggering injury necessitating the medical care, rather than the reimbursement of plaintiff's medical expense benefits. Under this view, the "loss" involved here occurred in 1982, about 3 1/2 years before Allstate assumed coverage for the group health

plan.

7. The Group Policy provides that "[t]he Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured." (12a of the Policy). "Eligible Expense" is defined as meaning "the following types of Expense incurred for an Injury or Sickness while insured . . . " (14a) Expense is defined as "a charge a person is legally obligated to pay. Expense is deemed to be incurred on the date the service or supply is furnished . . . " (25a).

(2)

Supreme Court, U.S.
FILED
JUL 13 1993
OFFICE OF THE CLERK

No. 92-2020

IN THE
Supreme Court of the United States
OCTOBER TERM, 1992

JONATHAN MARSH, a Minor,
by and through his Guardian Ad Litem,
Sharon Marsh,
Petitioner,
vs.
ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,
Respondent.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

JOHN L. VIOLA, ESQ.
Counsel of Record
Of Counsel
MARGARET LEVY, ESQ.
ADAMS, DUQUE & HAZELTINE
777 South Figueroa Street
Los Angeles, CA 90017
(213) 620-1240

Of Counsel
RALPH J. ELWART, ESQ.
3100 Sanders Road
Northbrook, IL 60062
(708) 402-7435

Attorneys for Respondent

BEST AVAILABLE COPY

Lawyers Brief Service • Appellate Brief Printers • (213) 613-1013 • (714) 720-1510

QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA welfare benefit plan expressly limits medical expense benefits to those expenses incurred while the group insurance policy which funds the plan is in force, and where Congress has expressly limited the requirement of "vested" benefits to pension plans, plan participants have a "vested" right to benefits for expenses incurred *subsequent* to the termination of the policy and the expiration of any extended benefit period, especially where the expenses stem from an accident occurring *prior* to the effective date of the policy?

2. Should this Court review the question whether, as a matter of federal common law, ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*, where the plan at issue is not ambiguous?

3. Should this Court review the question whether, where an ERISA welfare benefit plan expressly provides that a plan participant may elect to purchase conversion coverage which will be in accordance with applicable state law, and where state law provides for limited, minimum conversion benefits, that plan participants instead are entitled to the same level of benefits under the conversion policy as provided under the group insurance policy which funds the plan?

RULE 29.1 LISTING

1. Parents

Respondent Allstate Life Insurance Company of New York is a subsidiary of Allstate Life Insurance Company, Allstate Insurance Company, and Sears, Roebuck & Co.

2. Subsidiaries

Respondent Allstate Life Insurance Company of New York has no subsidiaries.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

RULE 29.1 LISTING ii

TABLE OF AUTHORITIES v

STATEMENT OF THE CASE 1

A. Nature Of The Case 1

B. Statement Of Facts 3

1. Petitioner's Coverage Under The Group Policy 3

2. The Group Policy Expressly Limits Benefits Payable To Those Expenses Incurred By An Insured While Coverage Is In Effect 4

3. The Group Policy Provides Extended Benefits Or Continued Benefits To Individuals In Certain Circumstances When Their Coverage Terminates . . . 6

4. The Group Policy Provides That Coverage May Be Converted To An Individual Policy Which Is In Accord With Applicable State Law 7

C. The District Court's Decision 8

D. The Ninth Circuit's Decision 9

Page

REASONS WHY THE PETITION SHOULD BE DENIED 10

I. THE FIRST QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE 11

A. ERISA Does Not Require The "Vesting" Of Welfare Benefits 11

B. Petitioner Is Not Entitled To "Vested" Benefits Under The Terms Of The Group Policy 13

C. Allstate Has No Liability To Petitioner Even Under His Own Theory of "Vesting." 16

D. Even State Law, Which Petitioner Urges The Court To Adopt As Federal Common Law, Does Not Impose A Vesting Requirement. 17

II. THE SECOND QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE 21

III. THE THIRD QUESTION DOES NOT PRESENT A QUESTION WHICH SHOULD BE REVIEWED BY THIS COURT 25

CONCLUSION 26

APPENDIX

Federal and State Statutes A-1

TABLE OF AUTHORITIES

Page

Cases

Allstate Insurance Co. v. Ellison
757 F.2d 1042 (9th Cir. 1985) 22

Altiere v. Blue Cross & Blue Shield
551 So.2d 290 (Ala. 1989) 20

Antley v. Blue Cross/Blue Shield, Inc.
515 So.2d 1314 (Fla.App. 1987) 20

Arkansas Blue Cross & Blue Shield, Inc.
v. Foerster
38 Ark.App. 228, 832 S.W.2d 280 (1992) 20

Blue Cross & Blue Shield of Florida, Inc.
v. Van Every
495 So.2d 923 (Fla. App. 1986) 20

Blue Cross - Blue Shield of Alabama
v. Turner
43 Ala.App. 542, 195 So.2d 807 (1966),
cert. denied, 280 Ala. 709,
195 So.2d 814 (1967) 19

Board of Trade v. Swiss Credit Bank
597 F.2d 146 (9th Cir. 1979). 23

Brown v. Blue Cross & Blue Shield of
Mississippi, Inc.
427 So.2d 139 (Miss. 1983) 18

Coleman v. General Elec. Co.
643 F.Supp. 1229 (E.D. Tenn. 1986),
aff'd, 822 F.2d 59 (6th Cir. 1987) 13

Page

Danzig v. Dikman
53 N.Y.2d 926, 423 N.E.2d 402,
440 N.Y.S.2d 925 (1981) 18

Duckett v. Piedmont Southern Life Ins. Co.
118 Ga.App. 3, 162 S.E.2d 531 (1968). 20

Erwin v. United Benefit Life Ins. Co.
70 N.M. 138, 371 P.2d 791 (1962). 19

Evans v. Safeco Life Ins. Co.
916 F.2d 1437 (9th Cir. 1990) 22

Ewalt v. Mereen-Johnson Machine Co.
414 N.W.2d 28 (S.D. 1987) 20

Fassio v. Montana Physicians' Service
170 Mont. 320, 553 P.2d 998 (1976). 19

Fields v. Blue Shield of California
163 Cal.App.3d 570,
209 Cal.Rptr. 781 (1985). 18

Firestone Tire & Rubber Co. v. Bruch
489 U.S. 101 (1989) 22, 24

Forbau v. Aetna Life Ins. Co.
36 Tex.Sup.J. 607, 1993 Tex. LEXIS 22
(May 5, 1993) 19, 20

Gamble v. Connecticut General Life Ins. Co.
55 A.D.2d 838, 390 N.Y.S.2d 326 (1976) 20

Guardian Life Ins. Co. v. Zerance
505 Pa. 345, 479 A.2d 949 (1984) 20

Page

Hamilton v. Travelers Ins. Co.
752 F.2d 1350 (8th Cir. 1985) 20

Harrington v. Prudential Ins. Co.
477 So.2d 1272 (La.App. 1985) 20

Hebert v. Red Simpson, Inc.
544 So.2d 751 (La.App. 1989) 20

Henricks v. Metropolitan Life Ins. Co.
7 Cal.2d 619, 61 P.2d 1162 (1936) 23

Holz Rubber Co. v. American Star Ins. Co.
14 Cal.3d 45, 533 P.2d 1055,
120 Cal.Rptr. 415 (1975). 23

Holzberg v. Mutual Life Ins. Co.
104 A.D.2d 972, 480 N.Y.S.2d 765 (1984),
appeal dismissed, 65 N.Y.2d 1025,
484 N.E.2d 668, 494 N.Y.S.2d 305 (1985) 20

Johnson v. G.A.B. Business Services, Inc.
165 Ga.App. 284, 300 S.E.2d 325 (1983) 20

Jones v. Mutual Liability Ins. Co.
336 S.W.2d 905 (Tex.App. 1960) 20

Keel v. Group Hospitalization Medical
Services, Inc.
695 F.Supp. 223 (E.D.Va. 1988) 20

Kunin v. Benefit Trust Life Ins. Co.
910 F.2d 534 (9th Cir.), *cert. denied*,
498 U.S. 1013 (1990) 24

Page

Le Blanc v. Travelers Ins. Co.
486 So.2d 828 (La.App. 1986) 20

Lippo v. Mobil Oil Corp.
776 F.2d 706 (7th Cir. 1985). 22

Lutsky v. Blue Cross Hospital Service, Inc.
695 S.W.2d 870 (Mo. 1985) 18

Massachusetts v. Morash
490 U.S. 107 (1989) 12

Matherne v. Prudential Ins. Co.
362 So.2d 823 (La.App. 1978) 20

Mezzacappo v. Travelers Ins. Co.
523 So.2d 291 (La. App.), *cert. denied*,
531 So.2d 473 (La. 1988) 20

Monninger v. Group Insurance Service
Center, Inc.
494 So.2d 41 (Ala. 1986) 20

Moore v. Metropolitan Life Ins. Co.
856 F.2d 488 (2nd Cir. 1988) 13

Myers v. Kitsap Physicians Service
78 Wash.2d 286, 474 P.2d 109 (1970) 18

Northwestern National Life Ins. Co. v. Glenn
568 S.W.2d 693 (Tex.App. 1978). 20

Pierrotti v. Life Ins. Co.
295 So.2d 826 (La.App.), *cert. denied*,
299 So.2d 790 (La. 1974) 20

Page

Quad Constr., Inc. v. Wm. A. Smith Contracting Co.
534 F.2d 1391 (10th Cir. 1976) 22

Record Club of America, Inc. v. United Artists Records, Inc.
890 F.2d 1264 (2nd Cir. 1989) 22

Service Life Ins. Co. v. Branscum
243 Ark. 463, 352 S.W.2d 586 (1962) 18

Sonneman v. Blue Cross & Blue Shield
403 N.W.2d 701 (Minn.App. 1987) 20

Sparks v. Republic Nat. Life Ins. Co.
132 Ariz. 529, 647 P.2d 1127, *cert. denied*,
459 U.S. 1070 (1982) 18

St. Paul Fire & Marine Ins. Co. v. Purdy
129 Ga.App. 356, 199 S.E.2d 567 (1973) 20

Taylor v. Continental Group
933 F.2d 1227 (3rd Cir. 1991) 22

Thacker v. Arkansas Blue Cross & Blue Shield
761 F.Supp. 654 (W.D. Ark. 1991). 20

Time Ins. Co. v. Williams
566 So.2d 14 (Fla.App. 1990) 20

Turner v. Local No. 302, International Brotherhood of Teamsters, etc.
604 F.2d 1219 (9th Cir. 1979) 13

Wardlow v. Kalispell General Hospital
164 Mont. 59, 518 P.2d 1164 (1974) 18

Page

Washer v. Continental Casualty Co.
418 S.W.2d 900 (Tex.App. 1967) 19

West v. Greyhound Corp.
813 F.2d 951 (9th Cir. 1987). 12

Wulffenstein v. Deseret Mutual Benefit Assoc.
611 P.2d 360 (Utah 1980) 20

Federal Statutes

29 U.S.C. § 1002(1) 12
29 U.S.C. § 1002(2)(a) 12
29 U.S.C. §§ 1021-1031 12
29 U.S.C. §§ 1051(1), 1081(a) 12
29 U.S.C. §§ 1051-61, 1081-86. 12
29 U.S.C. § 1053(a) 12
29 U.S.C. §§ 1101-4 12
29 U.S.C §§ 1161-1168 ("COBRA") 2, 26
29 U.S.C. § 1162 4
29 U.S.C. § 1162(5) 26

State Statutes

California Civil Code
§ 1641 23
§§ 1636, 1654 23

California Insurance Code
§ 10128.2 . . . . . .17, 18
§ 12670 25
§ 12684 26
§ 12692 18

Page

Treatises

3 Corbin, Contracts, §§ 542, 542A, 543, 579 22

Restatement (Second) of Contracts, §§ 212(1) and comment b, 202(1), 212(2) 22

Restatement (Second) of Trusts, § 164 22

Rules

Supreme Court Rule 10.1 25

No. 92-2020

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1992

JONATHAN MARSH, a Minor,
by and through his Guardian Ad Litem,
Sharon Marsh,
Petitioner,
vs.
ALLSTATE LIFE INSURANCE COMPANY
OF NEW YORK,
Respondent.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent, Allstate Life Insurance Company of New York ("Allstate"), respectfully requests that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. The decision is unpublished.

STATEMENT OF THE CASE

A. Nature Of The Case

Petitioner commenced this action against Allstate to obtain benefits under the group insurance policy at issue for medical expenses incurred by him *after* his father

voluntarily terminated coverage under the policy for himself and his dependents, including Petitioner, *after* his father voluntarily prematurely terminated Petitioner's right to receive continuation benefits pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, 29 U.S.C §§ 1161-1168 ("COBRA"), and *after* Petitioner's twelve month extension of benefits under the policy ran out.

Petitioner's claim is based on the concept of "vesting," a concept developed for accident and occurrence type insurance policies but having no application to medical expense policies, such as the policy at issue here. Moreover, even if the "vesting" theory were applicable here — and it is not — the accident or occurrence giving rise to Petitioner's alleged vested rights occurred over three years *before* the effective date of the Allstate policy. Indeed, the accident or occurrence took place when the insurance coverage of another insurer sued by Petitioner was in force. Accordingly, even if benefits "vested," they did not vest with respect to Allstate.

Faced with the fact that his coverage had been voluntarily terminated and that he was no longer insurable due to his serious medical condition, Petitioner brought this action under and pursuant to ERISA against Allstate and two other insurers which had previously insured the employee benefit plan at issue, the Equitable Life Assurance Society of the United States ("Equitable") and Travelers Insurance Company ("Travelers"). Petitioner, however, up to the present has only pursued his claims as against Allstate; the action has been stayed as against Equitable and Travelers pending final resolution of Petitioner's claims against Allstate.

B. Statement Of Facts

1. Petitioner's Coverage Under The Group Policy

Petitioner, the dependent son of Richard V. Marsh, an employee of Marsh Broadcasting, alleges that he suffered a serious accident in 1982 which rendered him totally disabled. [CR 1, ¶ 9.] By this lawsuit, he seeks payment of benefits for medical expenses incurred by him on or after May 1, 1990 and to be incurred by him in the future as a result of that 1982 accident.

Marsh Broadcasting provided medical expense insurance to its employees (and their dependents) by joining together with other companies to procure health insurance for their employees by association with Universal Broadcasting Corporation ("Universal"). Universal, in turn, procured insurance for the employees of its members from Equinet Small Group Network Trust ("Equinet"). [CR 1, ¶ 4.]

At the time of Petitioner's accident, in 1982, he was covered for and received benefits as a dependent under a policy issued by Equitable to Equinet. Subsequently, Equinet replaced the Equitable policy with a policy issued by Travelers. Equinet later replaced the Travelers policy with Allstate's Group Policy No. 64700289 (the "Group Policy"), issued to Equinet effective April 10, 1986. [CR 1, ¶ 4.]

Because Petitioner was receiving benefits under an extension of benefits pursuant to the policy issued by the predecessor insurer (Travelers), Allstate did not begin providing benefits to Petitioner until on or about January 1, 1988, almost six years after the swimming pool accident for which Petitioner seeks "vested benefits." [CR 1, ¶¶ 12, 13.]

Richard V. Marsh voluntarily terminated his (and Petitioner's) coverage under the Allstate Group Policy effective April 30, 1988. Mr. Marsh subsequently elected and Petitioner received continuation benefits pursuant to COBRA until April 30, 1989, when Mr. Marsh voluntarily terminated that coverage some six months before it otherwise would have expired.[1] [CR 29, p. 56, ¶ 3; 29 U.S.C. § 1162 (individual may elect up to 18 months of COBRA continuation coverage).] Then, after the voluntary termination of Petitioner's COBRA coverage on May 1, 1989, Allstate continued to provide benefits to Petitioner under the Extension of Benefits provision of the Group Policy. The extension expired on May 1, 1990. [CR 29, p. 56, ¶ 3.]

Richard V. Marsh elected to purchase conversion coverage for his family, including Petitioner, upon termination of his coverage under the Group Policy. [CR 29, pp. 33-34.]

2. The Group Policy Expressly Limits Benefits Payable To Those Expenses Incurred By An Insured While Coverage Is In Effect.

The Group Policy expressly limits the medical expense benefits available to "Eligible Expenses" incurred *while an individual is insured*:

---

[1] Although Petitioner claims that Allstate unilaterally terminated the group coverage [Petition, p. 5], there is absolutely no support in the record for this claim. Rather, as the District Court found, Mr. Marsh *voluntarily* terminated Petitioner's coverage under the Group Policy. [See, Petition, Appendix E, p. 38; CR 8, p. 34, ¶ 3.]

"MEDICAL BENEFIT

> The Medical Benefit is paid for Eligible Expenses *incurred* for an Injury or Sickness *while insured*." [CR 29, p. 69 (emphasis added).]

"Eligible Expense" is defined as meaning "the following types of Expense *incurred* for an Injury or Sickness *while insured* . . ." [CR 29, p. 71 (emphasis added).]

Further, the Group Policy defines "Expense" to mean:

> "a charge a person is legally obligated to pay. 'Expense' is deemed to be *incurred on the date the service or supply is furnished*. . . ." [CR 29, p. 82 (emphasis added).]

Finally, the Group Policy defines when coverage terminates as follows:

> "TERMINATION OF INSURANCE
>
> *EMPLOYEES' INSURANCE*
>
> Subject to the Continuance of Insurance provision, your insurance ends when the first of these events takes place:
>
> - the date the group policy . . . ends . . .
>
> The end of insurance will not affect any claim for a loss that took place while the insurance was in force. . . ."

A similar provision applies to dependents' insurance. [CR 29, pp. 64-65.]

Thus, the Group Policy provides benefits only for expenses incurred while coverage is in force; it does not provide benefits for expenses incurred after termination

of coverage, unless, as indicated below, the individual is entitled to continued or extended benefits.

3. The Group Policy Provides Extended Benefits Or Continued Benefits To Individuals In Certain Circumstances When Their Coverage Terminates.

The Group Policy provides additional, limited benefits to individuals who are totally disabled when their coverage would otherwise terminate.

In the case of the termination of the Group Policy, a one year extension of benefits is provided where an individual is totally disabled:

> "EXTENSION OF BENEFIT
>
> We will pay the Medical Benefit after a person's insurance ends, if:
>
> - the person is Totally Disabled on the day the insurance ends;
> - the person stays Totally Disabled until the *Expense is incurred*;
> - the *Expense is directly* related to the Total Disability;
> - the *Expense is incurred within 12 months after the day the insurance ends*; and
> - the person has not become insured by another group plan offering essentially the same coverages." [CR 29, p. 75 (emphasis added).]

Further, the Group Policy also provides that coverage may be continued if an employee is on a leave of absence or temporary layoff, for a period of no longer than six months. [CR 29, p. 65.]

And, regardless of whether coverage is extended or continued, the Group Policy provides a medical conversion privilege under which an insured whose coverage terminates because the Group Policy ends may elect to purchase an individual policy from Allstate without evidence of insurability. [CR 29, p. 81.]

4. The Group Policy Provides That Coverage May Be Converted To An Individual Policy Which Is In Accord With Applicable State Law.

The Group Policy provides that:

> "A person whose medical Expense Insurance ends may be eligible to buy health insurance coverage from us . . .
> "The form, benefits provided, premium and other terms of the conversion coverage will be in accord with all state laws and regulations which apply." [CR 29, p. 81.]

Pursuant to an enrollment form submitted to it by Mr. Marsh, Allstate Life Insurance Company enrolled Mr. Marsh and his family, including Petitioner, under its policy number 64400200 effective May 1, 1989 (the "Conversion Policy"). [CR 29, p. 34, ¶ 6.]

Although Petitioner claims that Mr. Marsh "detrimentally relied" on the Group Policy's "implicit promise" that the Conversion Policy would provide benefits

equivalent to those provided under the Group Policy [Petition, pp. 36-44], there is no support in the record for this claim. Mr. Marsh did not even know that a conversion policy was available until informed by Allstate that it intended to terminate the extended benefits being provided to Petitioner. [CR 2, p. 21]. Thus, contrary to Petitioner's claims [Petition, p. 43], Mr. Marsh could *not* have relied on an assumption that the conversion coverage would be equal to the group coverage until *after* the termination of the group coverage.

C. The District Court's Decision

Based on the express terms of the policy, the District Court, construing the *entire* policy, held that the Group Policy expressly limits benefits to expenses incurred while the policy is in effect and that Petitioner does not have a right to "vested" benefits. It therefore granted Allstate's motion for summary judgment. [Petition, Appendix E.]

In ruling in favor of Allstate, the District Court correctly noted that while the concept of "vesting" typically arises in the context of accident or casualty policies, under which liability is triggered by a "happening" or "occurrence," the Allstate Group Policy is a medical expense policy, under which liability is triggered by the "accrual of a medical expense." [Petition, Appendix E, pp. 41-42.] Under medical expense policies, the Court held, "an insured's right to benefits does not 'vest' at the occurrence of an injury." [*Id.* at 42.] Moreover, the Court noted that "it would be illogical to hold [that] [Petitioner's] rights 'vested' with Allstate in 1982 when, in point of fact, Allstate was not even the carrier at the time of [Petitioner's] accident." [*Id.*]

With respect to the conversion policy issue, the District Court found that there was no evidence to support Petitioner's claim that Mr. Marsh relied on any portion of the Group Policy with respect to his understanding as to the scope and level of conversion benefits. [Petition, Appendix E, pp. 58-59.]

D. The Ninth Circuit's Decision

The Ninth Circuit, in an unpublished Memorandum Decision filed January 22, 1992, affirmed the District Court's decision.

In doing so, the Court, applying the normal rules of contract construction, interpreted the Group Policy as a whole and found that it "unambiguously precludes the vesting of benefits . . ." [Petition, Appendix A, pp. 10-11.]

The Court also rejected Petitioner's argument with respect to the Conversion Policy. The Court held that "nothing in the [Group] Policy implies that [Petitioner] . . . should receive the same benefits under the conversion policy as he did under the [Group] Policy"; that Petitioner "has pointed to nothing in the [Group] Policy that would have caused a reasonable person to draw such inference"; and that Petitioner "has [not] offered any evidence that he held such belief and relied on it." [Petition, Appendix A, p. 10.]

By order filed March 17, 1993, the Ninth Circuit denied Petitioner's petition for rehearing and rejected the suggestion for rehearing en banc. [Petition, Appendix B.]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

In the first question, Petitioner urges this Court to ignore the plain wording of the contract and do that which Congress has refused to do, *i.e.*, adopt a rule requiring "vesting" for employee welfare benefit plans. This case does not properly raise that question, however. Rather, as both the District Court and the Ninth Circuit recognized, the plan language at issue is very detailed, specific and unique and unambiguously precludes vesting. Moreover, even if the plan language were ambiguous — and it is not — the "loss" allegedly giving rise to Petitioner's alleged right to "vested" benefits took place some three and one-half years before the policy was in force. This Court should not review a question which turns on the alleged ambiguity of a plan which in fact is not ambiguous and which, even if read in Petitioner's favor, would not result in a finding of "vested" benefits under the facts and circumstances of the case.

Similarly, the second question also is not properly raised by this case. The rule of *contra proferentem* that Petitioner urges the Court to establish construes insurance policies such that ambiguities are construed against the insurance company. Again, since the policy at issue simply is not ambiguous, and, even if it were, would still not require a finding in Petitioner's favor, the Court need not reach this question.

Finally, via the third question, Petitioner would have this Court step in and rewrite not only the policy, but state laws regarding conversion policy benefits. The Court should not do so.

Thus, this case turns on the specific wording of a number of very detailed, specific and unique provisions in the insurance policy at issue. The inquiry is highly fact specific. Although the questions presented by the Petition are important to the parties, there is no public importance associated with their outcome and the questions are not of sufficient importance to warrant review by this Court.

I.

THE FIRST QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The first question presented by the Petition is whether where the Group Policy expressly limits medical expense benefits to those expenses incurred while the policy is in force, and where Congress has expressly required "vested" benefits only for pension plans, this Court should rewrite the Group Policy, override Congress' legislation in this area, and establish federal law providing for the "vesting" of benefits under welfare benefit plans. In essence, Petitioner would have the Court find ambiguity where none exists and rewrite ERISA in a manner in which Congress has refused.

A. ERISA Does Not Require The "Vesting" Of Welfare Benefits.

ERISA specifically draws a distinction between "employee *pension* benefit plans" (which provide pension benefits which, by definition, vest for future availability) and "employee *welfare* benefit plans" (which provide, among other things, medical expense

benefits during the period coverage exists). *Compare* 29 U.S.C. § 1002(1) *with* § 1002(2)(a). Congress included both pension and welfare plans in ERISA's reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, and standards of fiduciary conduct governing plan administration, 29 U.S.C. §§ 1101-4. ERISA, moreover, assures the protection of vested *pension* benefits by prescribing participation requirements, funding requirements, and vesting and accrual schedules, 29 U.S.C. §§ 1051-61, 1081-86, and by providing that an employee's right to his or her normal retirement benefit shall be "nonforfeitable," 29 U.S.C. § 1053(a). Congress, however, expressly *excluded* welfare plans from ERISA's participation and vesting and funding requirements. 29 U.S.C. §§ 1051(1), 1081(a).

As this Court stated in *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989):

> ". . . ERISA's vesting and funding requirements do not apply to welfare benefit plans . . ."

Similarly, in *West v. Greyhound Corp.*, 813 F.2d 951, 954 (9th Cir. 1987), the Court held that:

> "ERISA . . . expressly exempts employee welfare benefit plans from the sections concerned with vesting and accrual. 29 U.S.C. §1051(1). While ERISA, in 29 U.S.C. §1322, also guarantees the payment of all nonforfeitable benefits, this protection is applicable only to pension, stock bonus or profit-sharing plans. 29 U.S.C. §1321(a); 26 U.S.C. §401(a). *There is no language in ERISA which provides for the accrual of welfare benefits or guarantees that such*

> *benefits are vested or nonforfeitable.*"
> (Emphasis added.)

Numerous other courts have agreed that ERISA does not require the "vesting" of benefits under welfare benefit plans. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 491 (2nd Cir. 1988); *Turner v. Local No. 302, International Brotherhood of Teamsters, etc.*, 604 F.2d 1219, 1225 n.5 (9th Cir. 1979); *Coleman v. General Elec. Co.*, 643 F.Supp. 1229 (E.D. Tenn. 1986), *aff'd*, 822 F.2d 59 (6th Cir. 1987).

Accordingly, since ERISA does not require the "vesting" of medical expense benefits, "vesting" should not be read into a plan, as Petitioner attempts to do here, unless the plan explicitly and unambiguously so provides.[2] As discussed below, the plan at issue simply does not provide for the vested benefits Petitioner seeks. And, even if it did so provide, Allstate was not even the insurance carrier at the time of the accident or occurrence giving rise to Petitioner's alleged vested rights.

B. Petitioner Is Not Entitled To "Vested" Benefits Under The Terms Of The Group Policy.

Petitioner bases his claim to "vested" benefits on a reading of isolated phrases in the Group Policy. An analysis of the *entire* policy, however, reveals that Petitioner's claims are misplaced and that the Group Policy does not provide the "vested" benefits he seeks.

---

[2] Petitioner's claim that "[i]n the court below, Allstate argued that . . . vesting could not be applied to an employee welfare benefit plan" [Petition, p. 29] is incorrect. In fact, Allstate's argument in the Ninth Circuit on this score was identical to the position set forth by Allstate in this Brief in Opposition.

Under the express terms of the Group Policy, an individual is entitled to medical benefits only for expenses incurred while the policy is in force. In particular, the Group Policy provides:

> "The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness *while insured.*" (Emphasis added.)

The clear intent of this language was to provide coverage only with respect to expenses incurred while the policy was in force. That intent was further clarified by the provision of the Group Policy stating that an individual's insurance ends on the date of termination of the policy:

> "Your insurance terminates . . . the date the Group Policy . . . ends."

The phrasing of the Group Policy not only provides for benefits for covered medical expense charges incurred by an insured individual "while insured," but it also extends coverage beyond termination only for a limited time period, and only in limited circumstances, under the Extension of Benefits and Continuance of Insurance provisions.

Thus, when the Group Policy is read as a whole, it provides only for limited post-termination benefits. If Petitioner's claim that he is entitled, after termination of Group Policy coverage, to benefits for expenses incurred after termination, is correct, it would render the Extension of Benefits and Continuance of Insurance provisions meaningless.

In the face of this clear language, Petitioner contends that one phrase in the Group Policy, when viewed in isolation, provides him with a right to "vested" benefits.

The phrase upon which Petitioner relies is "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force."[3] According to Petitioner, this provision means that termination of the policy will not affect claims for eligible expenses incurred after the termination of the policy for injury or sickness that occurred while the policy was in force. [Petition, pp. 9-14.]

To reach this result, however, Petitioner would ignore those portions of the Group Policy limiting benefits to expenses incurred while the policy is in effect and limiting benefits available post-termination to continued and extended benefits. Indeed, it is submitted that even when viewed in isolation the provision at issue does not give rise to "vested" benefits. Instead, by its plain terms, the provision merely states that the termination of coverage will not affect *claims* for expenses incurred prior to policy termination. This reading is reinforced by the fact that the provision is found in the general, "Insuring Provisions" section of the policy, which applies to life and accidental death insurance benefits as well as to

---

[3] Petitioner's claim that Allstate "itself admitted in its Opposition to the Preliminary Injunction [that] this [provision] is a classic 'vesting' provision" [Petition, p. 9], is nothing but wishful thinking. In fact, the record, which Petitioner has conveniently ignored throughout the Petition, indicates that Allstate merely observed that the provision in question refers to the situation where, under the "Accidental Death and Dismemberment Benefit" portion of the Group Policy, benefits are payable if the specific loss in question, *i.e.*, death or loss of a limb or an eye, occurs within 90 days of an accident. [See CR 8, p. 17, n.3.] Allstate made this observation because, as the District Court noted, in the context of an *accident* policy the event giving rise to liability is an accident or occurrence, whereas in *medical expense* policies, the "event" giving rise to liability is the incurring of medical expenses. [See Petition, Appendix E, pp. 41-43, pp. 62-63, endnote 6.]

medical expense insurance benefits. In this regard the provision operates, for example, to provide that accidental death benefits will be paid if the specific loss in question, *i.e.*, death or loss of limb or an eye, occurs within 90 days of an accident. [CR 29, p. 53.]

Petitioner attempts to subvert the plain language of the policy by inventing a new provision. Under Petitioner's "new and improved" version of the policy, even though the Group Policy requires that an expense be incurred "while insured" for benefits to be payable, the insured remains "insured" because benefits have "vested." [Petition, pp. 12-13.] This argument is pure sophistry. The very issue in this case is *whether* the insured remains "insured" because benefits have "vested." Petitioner attempts, by this tortured construction, to "overlook the obvious"; if insurance was still "in force" as he claims, this case would never have arisen.

Thus, under the express terms of the Group Policy, benefits are limited to those expenses incurred while the policy is in effect and during any period of extended benefits.

C. Allstate Has No Liability To Petitioner Even Under His Own Theory of "Vesting."

Even assuming, for the sake of argument, that Petitioner's construction of the Group Policy is correct, Allstate has no liability to Petitioner for "vested" benefits.

Again, the language which Petitioner claims gives rise to his "vested" rights is as follows:

> "[t]he end of insurance will not affect any claim for a loss that took place while the insurance was in force."

Here, the alleged "loss" at issue is Petitioner's 1982 swimming pool injury. That "loss" did not occur while the Group Policy was in force, but rather, some 3-1/2 years *before* the Group Policy was in force and during coverage by a prior carrier, which carrier is also a defendant in the action. As noted above, Allstate's Group Policy does not provide benefits for events occurring prior to the date it was in effect. If benefits have "vested," as Petitioner contends, then they have vested with respect to the carrier whose policy was in force at the time of the "loss," and not with respect to Allstate. This other carrier, in fact, is a named defendant in Petitioner's Complaint. [CR 1.]

D. Even State Law, Which Petitioner Urges The Court To Adopt As Federal Common Law, Does Not Impose A Vesting Requirement.

Not only does ERISA not impose a vesting requirement and not only does the Group Policy not provide for vested benefits, but even state law, which Petitioner urges the Court to adopt as federal common law [Petition, pp. 24-29], does not impose a vesting requirement.

California law, for example, expressly negates the existence of the "vested rights" which Petitioner claims. California Insurance Code section 10128.2, entitled "Extension of benefits; discontinuance of policy," provides a 12 month extension of benefits period for employees or dependents who become totally disabled while insured under the policy and who continue to be totally disabled upon the termination of the policy.

In addition, California Insurance Code section 12692 provides a 90-day extension of benefits period in certain circumstances where the section 10128.2 continuance is not applicable.

California law, therefore, expressly defines the post-termination benefits that an insurance company must make available to individuals when their group coverage terminates.

Further, although Petitioner claims that "[v]esting of medical and health insurance benefits has been adopted as a rule of law in numerous states" [Petition, p. 24], a review of the cases cited by Petitioner for this proposition reveals that they are based upon elements or factors not present here, *i.e.*, ambiguous policy language;[4] the reasonable expectations of the insured;[5] modifications of policy language to exclude or limit coverages of expenses stemming from illnesses or disease commencing under more expansive policy language;[6] policies insuring the individuals for *accidents* occurring during the policy period;[7] policies expressly providing that charges

---

[4] *Wardlow v. Kalispell General Hospital*, 164 Mont. 59, 518 P.2d 1164 (1974); *Lutsky v. Blue Cross Hospital Service, Inc.*, 695 S.W.2d 870 (Mo. 1985); *Danzig v. Dikman*, 53 N.Y.2d 926, 423 N.E.2d 402, 440 N.Y.S.2d 925 (1981); *Myers v. Kitsap Physicians Service*, 78 Wash.2d 286, 474 P.2d 109 (1970); *Sparks v. Republic Nat. Life Ins. Co.*, 132 Ariz. 529, 647 P.2d 1127, *cert. denied*, 459 U.S. 1070 (1982).

[5] *Brown v. Blue Cross & Blue Shield of Mississippi, Inc.*, 427 So.2d 139 (Miss. 1983); *Myers v. Kitsap Physicians' Service, supra.*

[6] *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985); *Danzig v. Dikman, supra.*

[7] *Service Life Ins. Co. v. Branscum*, 243 Ark. 463, 352 S.W.2d 586 (1962).

incurred after termination would be covered;[8] and policies covering specific conditions beginning during the policy period.[9]

Indeed, one of the cases cited by Petitioner, *Fassio v. Montana Physicians' Service*, 170 Mont. 320, 553 P.2d 998 (1976), held that the rule of vesting was *not* applicable to a medical expense policy, such as the Group Policy involved in this case. In addition, while Petitioner lists the State of Texas as being a jurisdiction which has adopted vesting as "a rule of law" [Petition, pp. 24, 26], he fails to inform the Court of the Supreme Court of Texas' recent decision in *Forbau v. Aetna Life Ins. Co.*, 36 Tex.Sup.J. 607, 1993 Tex. LEXIS 22 (May 5, 1993), in which the court rejected plaintiff's argument that she was entitled to plan benefits beyond the one year extension of benefits period provided by the policy after cancellation of the policy.

Moreover, the vast majority of cases dealing with this issue have rejected Petitioner's "vesting" argument and have held that a group health insurer is *not* required to provide coverage in connection with expenses for *injuries suffered before* the policy is terminated where the *expenses are incurred after* termination. The courts' reasoning is generally premised on two factors, both of which are present here: (1) that such policies expressly state that coverage terminates on the date the policy terminates; and, (2) that the policies provide express provisions detailing the circumstances wherein coverage

---

[8] *Erwin v. United Benefit Life Ins. Co.*, 70 N.M. 138, 371 P.2d 791 (1962); *Washer v. Continental Casualty Co.*, 418 S.W.2d 900 (Tex.App. 1967).

[9] *Blue Cross - Blue Shield of Alabama v. Turner*, 43 Ala.App. 542, 195 So.2d 807 (1966), *cert. denied*, 280 Ala. 709, 195 So.2d 814 (1967).

will be provided after termination of the policy, *i.e.*, an extension or continuation of benefits.[10]

Indeed, many courts base their conclusion that there is no "vested" right to continued coverage *solely* on the first factor.[11]

---

[10] *See, e.g., Monninger v. Group Insurance Service Center, Inc.*, 494 So.2d 41 (Ala. 1986); *Blue Cross & Blue Shield of Florida, Inc. v. Van Every*, 495 So.2d 923 (Fla. App. 1986); *Mezzacappo v. Travelers Ins. Co.*, 523 So.2d 291 (La. App.), *cert. denied*, 531 So.2d 473 (La. 1988); *Pierrotti v. Life Ins. Co.*, 295 So.2d 826 (La.App.), *cert. denied*, 299 So.2d 790 (La. 1974); *Sonneman v. Blue Cross & Blue Shield*, 403 N.W.2d 701 (Minn.App. 1987); *Gamble v. Connecticut General Life Ins. Co.*, 55 A.D.2d 838, 390 N.Y.S.2d 326 (1976); *Guardian Life Ins. Co. v. Zerance*, 505 Pa. 345, 479 A.2d 949 (1984); *Forbau v. Aetna Life Ins. Co., supra; Northwestern National Life Ins. Co. v. Glenn*, 568 S.W.2d 693 (Tex.App. 1978); *Jones v. Mutual Liability Ins. Co.*, 336 S.W.2d 905 (Tex.App. 1960).

[11] *See, e.g., Hamilton v. Travelers Ins. Co.*, 752 F.2d 1350 (8th Cir. 1985); *Thacker v. Arkansas Blue Cross & Blue Shield*, 761 F.Supp. 654 (W.D. Ark. 1991); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D.Va. 1988); *Altiere v. Blue Cross & Blue Shield*, 551 So.2d 290 (Ala. 1989); *Arkansas Blue Cross & Blue Shield, Inc. v. Foerster*, 38 Ark.App. 228, 832 S.W.2d 280 (1992); *Time Ins. Co. v. Williams*, 566 So.2d 14 (Fla.App. 1990); *Johnson v. G.A.B. Business Services, Inc.*, 165 Ga.App. 284, 300 S.E.2d 325 (1983); *St. Paul Fire & Marine Ins. Co. v. Purdy*, 129 Ga.App. 356, 199 S.E.2d 567 (1973); *Duckett v. Piedmont Southern Life Ins. Co.*, 118 Ga.App. 3, 162 S.E.2d 531 (1968); *Antley v. Blue Cross/Blue Shield, Inc.*, 515 So.2d 1314 (Fla.App. 1987); *Hebert v. Red Simpson, Inc.*, 544 So.2d 751 (La.App. 1989); *Le Blanc v. Travelers Ins. Co.*, 486 So.2d 828 (La.App. 1986); *Harrington v. Prudential Ins. Co.*, 477 So.2d 1272 (La.App. 1985); *Matherne v. Prudential Ins. Co.*, 362 So.2d 823 (La.App. 1978); *Holzberg v. Mutual Life Ins. Co.*, 104 A.D.2d 972, 480 N.Y.S.2d 765 (1984), *appeal dismissed*, 65 N.Y.2d 1025, 484 N.E.2d 668, 494 N.Y.S.2d 305 (1985); *Ewalt v. Mereen-Johnson Machine Co.*, 414 N.W.2d 28 (S.D. 1987); *Wulffenstein v. Deseret Mutual Benefit Assoc.*, 611 P.2d 360 (Utah 1980).

Accordingly, Petitioner's argument that this Court should adopt a "vesting" rule as federal common law for ERISA plans is fatally flawed. The express terms of the policy at issue, federal and state legislation and case law all do not provide Petitioner with the "vested" rights he implores this Court to establish. Further, even if the Court were to establish such a rule, it would not apply to Petitioner because the accident in question occurred prior to the effective date of Allstate's policy. The Court, therefore, should not review the first question.

II.

THE SECOND QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The second question presented by the Petition is whether as a matter of federal common law ambiguities in an insurance policy issued to an ERISA plan are to be construed under the rule of *contra proferentem*. Petitioner also appears to propose a different rule of construction for insured as opposed to self-funded ERISA plans, and perhaps state a third rule for claims under self-funded plans with stop-loss insurance coverage.

This question is not of sufficient importance to warrant review by this Court. Rather, this case does not properly present this question because, as noted above, there is no ambiguity in the plan at issue.

As shown below, Petitioner confuses the difference between rules of interpretation, which seek the parties' intent, and contract rules of construction, which are applied only if the intent cannot be determined. Under the law of trusts, which is incorporated in ERISA, the plan documents must be read by the plan administrator

not under the contract doctrine of *contra proferentem*, but in light of all the circumstances, including the settlor's intent. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989); *Restatement (Second) of Trusts*, § 164. The same is true under the law of contracts. *Restatement (Second) of Contracts*, §§ 212(1) and comment b, 202(1), 212(2); 3 Corbin, *Contracts*, §§ 542, 542A, 543, 579.

It is submitted that terms in ERISA insurance policies, just like terms in non-ERISA insurance policies, are to be interpreted in light of the settlor's intent and "in an ordinary and popular sense as would a [person] of average intelligence. . . . We will 'not artificially create ambiguity where none exists.'. . . 'If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.' " *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (citations omitted), quoting *Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985).

Contra proferentem is not applied under contract law except as a constructional tool of last resort when the parties' intent cannot be determined. *Taylor v. Continental Group*, 933 F.2d 1227, 1233-34 (3rd Cir. 1991); *Record Club of America, Inc. v. United Artists Records, Inc.*, 890 F.2d 1264, 1271 (2nd Cir. 1989); *see also, Lippo v. Mobil Oil Corp.*, 776 F.2d 706, 714 n. 15 (7th Cir. 1985); *Quad Constr., Inc. v. Wm. A. Smith Contracting Co.*, 534 F.2d 1391, 1394 (10th Cir. 1976). Judge (now Justice) Anthony M. Kennedy summed up this point as follows:

> "A rule for construing contracts against the author is not an alternative to construing it as the parties intended. It is to be applied after the

> court has inquired into the intent of the parties, and then only if its meaning remains uncertain."

Board of Trade v. Swiss Credit Bank, 597 F.2d 146, 149 (9th Cir. 1979).

Indeed, under any rule of interpretation, be it federal law, California law, or the law of some other jurisdiction, the Court must apply certain rules of interpretation to ascertain the intent of the parties to a contract *prior* to using a rule of construction, such as the one resolving ambiguity against the drafting party. *See, e.g.*, California Civil Code §§ 1636, 1654. These rules require the Court to construe the contract as a whole, not in isolated parts, so as to give effect to every provision. *See, e.g.*, California Civil Code § 1641. Whenever reasonably possible, meaning must be given to every sentence, clause and word, so as to avoid rendering parts of a policy inoperative. *Holz Rubber Co. v. American Star Ins. Co.*, 14 Cal.3d 45, 533 P.2d 1055, 120 Cal.Rptr. 415 (1975). A construction which would give effect to one sentence of a policy, but completely ignore an entire paragraph dealing with the same subject matter, is *not* required by the rule, espoused by Petitioner, that an insurance policy should be liberally construed in favor of the insured. *Henricks v. Metropolitan Life Ins. Co.*, 7 Cal.2d 619, 631, 61 P.2d 1162 (1936).

The proper application of the rules of contract interpretation leads to the conclusion that Petitioner has no right to benefits under the Group Policy for expenses incurred by him after termination of coverage.[12]

---

[12] It is especially important that these rules be applied in determining whether medical expense benefits "vest" under employee welfare benefit plans. It would be anomalous to utilize state common law rules of construction to bring in, via the "backdoor," a mandated

(continued)

Indeed, the terms of the Group Policy are not even ambiguous under the very case relied on by Petitioner for this proposition, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990). Even the *Kunin* court recognized that the rule of *contra proferentem* is applied only "if after applying the normal principles of contractual construction, 'the insurance contract is fairly susceptible of two different interpretations . . .' " *Id.* at 539 (citation omitted). Moreover, the *Kunin* court itself proceeded to analyze the entire policy at issue in that case, not just an isolated phrase or phrases, *id.* at 541, as Petitioner would have this Court do here. Only because it determined that it could not cure the ambiguity of a term by reference to the plan as a whole did the *Kunin* court apply the rule of *contra proferentem*. [*Id.* at 541.]

In his attempt to somehow, someway, obtain a benefit for which he did not bargain and which Congress refused to grant, Petitioner ignores this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that in construing the terms of the policy, the Court must seek out the intent of the trustor. The Court should not, as Petitioner urges it to do, construe the policy in an effort to find ambiguities where none exist and to construe them against the drafter. The Court may not prefer one party's interpretation over that of another.

What Petitioner is really seeking is the right to ignore both well-established state common law rules of contract interpretation and this Court's rules regarding the construction of ERISA plans and instead read an isolated word or phrase in a group insurance policy in isolation from and in conflict with the rest of the agreement.

(fn. continued)
vesting requirement which Congress itself rejected. The Court should not utilize preempted state law rules to rewrite ERISA.

The Court should not review the second question, which is not properly presented by this case.

III.

THE THIRD QUESTION DOES NOT PRESENT A QUESTION WHICH SHOULD BE REVIEWED BY THIS COURT

The third question presented by the Petition is whether the Court should step in and rewrite the policy and state law providing for limited, minimum conversion benefits to provide Petitioner with the same level of benefits provided under the Group Policy.

This question does not involve a federal question, let alone a split among the circuits or a question of general importance, to warrant review by the Court under Supreme Court Rule 10.1.

Quite simply, it is undisputed that the Group Policy meets the requirements of California law with respect to conversion policies. California law does not require a conversion policy to provide the same or similar benefits as does the group policy providing the right to convert.[13] Rather, the legislature made a policy decision — as it did with the vesting issue — that only a minimum level of benefits is required to be provided under conversion policies. *See*, California Insurance Code §§ 12670 (Legislature's intent to ensure that persons converting from group to individual policies "have access to minimum benefits" under the converted

[13] Mr. Marsh admits that he understood that Allstate would provide the minimum benefits required by California law. [CR 31, p. 3, ¶ 5.]

policy); 12684 (providing for minimum conversion benefits). Those minimum levels have been met here. *Compare* CR 1, pp. 41-42 and CR 29, pp. 40-49, *with* California Insurance Code § 12684.

Further, Congress, as a matter of federal law, has provided, in certain circumstances, that ERISA plan participants may continue the coverage provided by the group policy for up to eighteen months. 29 U.S.C. §§ 1161-68. In addition, plan participants have "the option of enrollment under a conversion health plan *otherwise generally available* under the plan" when such continuation coverage expires. 29 U.S.C. § 1162(5) (emphasis added). If Congress wished to impose a further requirement that such continuation coverage be made available for a longer period of time, or that the "conversion health plan" available under the group policy funding the plan offered the same level of benefits as did the group policy, it could easily have done so.

Accordingly, this Court need not review the third question.

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions of limited significance because they were resolved against Petitioner by both courts below based upon the particular and highly unique facts of the case. When these facts are analyzed, it is clear that the terms of the policy itself, statutory law and decisional law simply do not provide Petitioner with the right to vested benefits he seeks.

The Petition is nothing more than a last-gasp effort by Petitioner to have this Court step in, rewrite the policy, and do what both Congress and the California legislature

have refused to do in requiring that employee welfare benefits "vest" and that conversion policies provide the same level of benefits as the group policies providing the right to convert. The Petition, therefore, should be denied.

DATED: July 13, 1993.

Respectfully submitted,

JOHN L. VIOLA
Counsel of Record

Of Counsel
MARGARET LEVY

ADAMS, DUQUE &
HAZELTINE

Of Counsel
RALPH J. ELWART

Attorneys for Respondent
Allstate Life Insurance Company
of New York

APPENDIX

BEST AVAILABLE COPY

STATUTES

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2) (A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program —

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating benefits under the plan or the method of distributing benefits from the plan. . . .

29 U.S.C. § 1162. Continuation coverage

For purposes of section 1161 of this title the term "continuation coverage" means coverage under the plan which meets the following requirements:

(1) Type of benefit coverage

The coverage must consist of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred. If coverage is modified under the plan for any group of similarly situated beneficiaries, such coverage shall also be modified in the same manner for all individuals who are qualified beneficiaries under the plan pursuant to this part in connection with such group.

(2) Period of coverage

The coverage must extend for at least the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

(A) Maximum required period

(i) General rule for terminations and reduced hours

In the case of a qualifying event described in section 1163(2) of this title, except as provided in clause (ii),

the date which is 18 months after the date of the qualifying event. . . .

(5) Conversion option

In the case of a qualified beneficiary whose period of continuation coverage expires under paragraph (2)(A), the plan must, during the 180-day period ending on such expiration date, provide to the qualified beneficiary the option of enrollment under a conversion health plan otherwise generally available under the plan.

California Insurance Code § 10128.2. Extension of benefits; discontinuance of policy

Every policy containing a life insurance benefit shall contain a reasonable extension of such benefit upon discontinuance of the policy with respect to employees who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. Every policy containing a loss of time benefit, or a hospital, medical, or surgical expense benefit shall contain a reasonable extension of such benefits upon discontinuance of the policy with respect to employees or dependents who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. . . .

(d) Every policy providing hospital, medical or surgical benefits on an expense-incurred or service basis shall be deemed to include a reasonable extension of such benefits upon discontinuance of the policy if it provides benefits for covered expenses directly relating to the condition causing total disability existing at the time premium payments for the employee or dependent

cease and incurred during a period of not less than 12 months thereafter, which period shall not be interrupted by discontinuance of the policy.

That extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that employee or dependent without limitation as to the disabling condition.

(e) The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy.

California Insurance Code § 12670. Legislative intent

It is the intent of the Legislature to ensure that persons covered by a group policy, who become ineligible for such coverage have access to minimum benefits pursuant to this part by requiring employers, employee organizations, and other entities which provide such coverage to their employees or members to also make available conversion policies for such persons and to ensure that insurers as herein defined offer conversion policies. In addition, it is the intent of the Legislature to encourage the continuation of group health coverage by requiring the entities herein defined to make available continuation benefits for widows, widowers, divorced spouses, and dependents who were covered by the group policy on the date of termination of coverage.

California Insurance Code § 12684. Major medical group coverage; minimum conversion benefits

Subject to the provisions and conditions of this part, if the group policy from which conversion is made provides the employee or member with major medical or comprehensive medical insurance, the employee or member shall be entitled to obtain a converted policy providing comprehensive medical coverage providing at least the following benefits:

(a) A payment per covered person for all covered medical expenses incurred during the person's lifetime equal to one hundred thousand dollars ($100,000); provided, however, that for treatment of mental illness payment may be limited to ten thousand dollars ($10,000) during the person's lifetime.

(b) Payment of benefits at the rate of 75 percent of covered medical expenses; provided, however, that if coverage is provided for expenses incurred for outpatient treatment of mental illness, payment of benefits may be at the rate of 50 percent of such covered expenses, and the insurer may limit the amount of covered expense for each outpatient visit and the amount of benefits payable for expenses incurred during each calendar year for that outpatient treatment.

(c) A cash deductible for each benefit period at the option of the insured of two hundred dollars ($200), five hundred dollars ($500), or one thousand dollars ($1,000), but not less than the cash deductible which applied to the insured under the group policy which entitles him or her to a converted policy.

(d) Covered medical expenses shall include the charges for a semiprivate hospital room and board, but need not exceed the lesser of one hundred fifty dollars ($150) per day or the hospital's most common charge for a semiprivate room, covered expenses for

intensive care shall be at least two and one-half times the covered hospital room and board charge. The maximum dollar amount for hospital room and board daily covered expense may be redetermined by the commissioner as to conversion coverage issued after the redetermination. That redetermination shall not be made more often than once in three years. The maximum dollar amount redetermined by the commissioner shall not exceed the average semiprivate room rate then charged in the state.

(e) Covered expenses under this section shall include benefits for expense incurred by the employee, member, or spouse in connection with pregnancy, provided that:

(1) The pregnancy commenced while covered under the group policy from which conversion was made;

(2) The expense is of a type which would have been covered under such group policy; and

(3) The conversion policy is in force when the expense is incurred.

(f) Covered expense under this section need not include expense for dental or vision care, or other optional benefits not normally offered by the insurer under a major medical or comprehensive medical expense plan.

California Insurance Code § 12692. Continuation benefit coverage; duration; eligible dependents; conditions of availability of coverage

On and after January 1, 1985, every insurer and nonprofit hospital service plan issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer to group policyholders a continuation benefit which if selected, shall have a duration of at

least 90 days and which shall be offered consecutively to any federal requirement for continuation benefits. The terms and conditions shall include continuation benefit coverage for widows, widowers, divorced or legally separated spouses, spouses of covered employees becoming entitled to benefits under Title XVIII of the Social Security Act, and their dependents, including dependent children who cease to be dependent children under the plan, who were covered by the group contract on the date of termination of coverage. However, any existing provisions of law regarding termination of a dependent child status shall not be affected by this section.

The continuation of coverage shall be available only under the following conditions:

(a) Those eligible remain within the State of California, although the departure of a dependent child to another state shall not invalidate the continuation provisions for any other family members.

(b) Those eligible do not marry or remarry, although the marriage of any dependent child shall not invalidate the continuation provisions for other family members.

(c) Those eligible are not eligible for any comparable state, federal, or private group medical plan, although the eligibility of any dependent child shall not invalidate the continuation provisions for other family members.

(d) Those eligible do not find employment with an employer that has a group plan of its own, even if the plan is less substantive, although the entry into such an employee plan by a dependent child shall not invalidate the continuation provisions for other family members.

(e) The group policy is not terminated or the employer's participation in the group policy is not terminated.

(f) Those eligible do not knowingly furnish incorrect information or otherwise improperly obtain the benefits of the plan.

(g) The continuing individual shall pay the premium amount in the manner specified in the group policy for both his or her share of the premium and the group policyholder's share, if any.

(h) Eligible persons under this section shall be notified in the same manner required for conversion notification pursuant to Section 12689. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.